A Center for
Adoption Services

206.954.5253
Dru@DruGroves.org
www.DruGroves.org

Child Medical Report

Name of Physician: _____ Date: _____

Address of Physician: _____

Please return to the adoptive applicant.

A Center for Adoption Services requests a medical report on _____
We need to know if this child has been seen regularly by you, and whether there is any evidence of any physical problems or issues of which we should be aware.

MEDICAL HISTORY: _____

_____

_____

UPDATE ON IMMUNIZATIONS: _____

_____

_____

ILLNESSES: _____

_____

_____

COMMENTS OR IMPRESSIONS: _____

_____

_____

I authorize my physician to release information to A Center for Adoption Services

_____
ADOPTIVE APPLICANT'S SIGNATURE

(Please use back side for additional space.
We appreciate your comments.)

_____
PHYSICIAN'S SIGNATURE

_____
PRINT NAME OF PHYSICIAN

_____
DATE