



**MEDICAL FORM
(FOR HOUSEHOLD MEMBERS AGE 18 AND UP)**

Name _____ Date of Birth _____
Social Security Number: _____

Has this person been determined to be free from tuberculosis in accordance with the acceptable screening methods of the Department of Health?

Date of Tuberculin test _____

If, in your opinion, a Tuberculin test is inadvisable for this person, check here _____

Date of chest x-ray (when applicable) _____

BLOOD TEST

HIV _____ Date _____ Results _____
RPR _____ Date _____ Results _____

Does this individual have any contagious or infectious diseases? _____

Does this individual have any serious chronic disease? _____

In your opinion, is this individual physically, psychologically and emotionally able to adopt and care for a child or children?

COMMENTS: _____

MD signature

MD printed name

Date

Address