

**STATE OF ILLINOIS**  
**DEPARTMENT OF CHILDREN AND FAMILY SERVICES**  
**Medical Evaluation of an Adult in a Foster or Adoptive Home**

Form Distribution  
- Licensing worker/supervisor  
- Kept in a sealed envelop in the  
licensing file and marked  
"CONFIDENTIAL"

Name of Person Examined: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ How long have you been treating this patient? \_\_\_\_\_

**This form will aid the Department in determining the physical wellness and capabilities of adults in foster or adoptive homes who are or may be caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and for the foreseeable future (five to ten years). If you have any medical or health questions or concerns, please call the Department of Children and Family Services at 312-814-5693.**

I am available to discuss further health concerns

Concerns or questions about confidentiality issues may be address to:

\_\_\_\_\_  
Name Phone

**I. HISTORY**

1. Check any health problems:

- |  |  |  |                                    |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Tremors   |
| <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Sleep Disorder    | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Poor Ambulation | <input type="checkbox"/> Confusion         | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weak/Frail      | <input type="checkbox"/> Dementia          |                                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Vision          | <input type="checkbox"/> Epilepsy/Seizures |                                    |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Hearing         | <input type="checkbox"/> Strokes/Paralysis |                                    |

Explain **all** medical condition(s) checked and any other chronic conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are there any condition(s) that are progressive in nature? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next \_\_\_5 years, \_\_\_10 years \_\_\_15 years? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Medication(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any physical limitations as a result of medication(s)? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol  \_\_\_\_\_ Drugs  \_\_\_\_\_
Tobacco  \_\_\_\_\_ Other  \_\_\_\_\_

6. Date \_\_\_\_\_ Result of Tuberculin Test (initial exam only): \_\_\_\_\_

7. Date \_\_\_\_\_ Result of Chest X-Ray (if necessary): \_\_\_\_\_

II. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

- 1. Lift a child: Under 6 months Yes  No  6 months to 3 years Yes  No 
2. Walk/maneuver 50-100 feet without major difficulties: Yes  No 
3. Bend/stoop, kneel, reach: Yes  No 
4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes  No 
If Yes, what type? \_\_\_\_\_
5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:
Lift from a bed to chair, etc. Yes  No  Don't Know 
Frequent Feedings Yes  No  Don't Know 
Frequent Suctions Yes  No  Don't Know 
Frequent Monitoring Yes  No  Don't Know 
Frequent Medication Yes  No  Don't Know 
Frequent Nebulizations Yes  No  Don't Know 
Frequent Treatments Yes  No  Don't Know

Are any limiting conditions temporary? Yes  No

If yes, which condition(s): \_\_\_\_\_

For each condition, how long will the limitation exist? \_\_\_\_\_

I certify that this individual is found free from symptoms of communicable disease.

Yes  No  If No, explain: \_\_\_\_\_

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes  No  If No, explain: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_