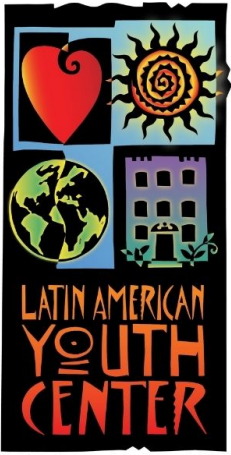


**LATIN AMERICAN YOUTH CENTER
ESPERANZA PROGRAM**

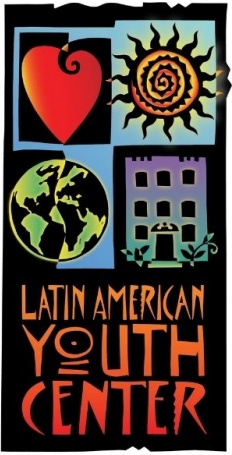
**MEDICAL REPORT FOR APPLICANT AND ALL MEMBERS RESIDING IN
PROSPECTIVE OR LICENSED FOSTER HOME**

To be completed by the applicant.



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Full Name	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Briefly describe and give approximate dates for the following:	Major Illnesses:
	Hospitalization:
	Surgery:
	Accidents:
	Pregnancies:
	Psychiatric/Mental Health Treatment:
	Alcohol/Drug Treatment:
Family medical history – is there a history of:	Allergies: _____ Yes _____ No Diabetes: _____ Yes _____ No Heart disease: _____ Yes _____ No Cancer: _____ Yes _____ No Alcohol/drug use: _____ Yes _____ No Mental Illness/Disability: _____ Yes _____ No Hypertension: _____ Yes _____ No



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	Lung disease: _____ Yes _____ No Anemia: _____ Yes _____ No Other (specify): _____ Yes _____ No
Describe your general health condition <i>(please list any medication you are taking)</i>	
Are you currently receiving any treatment, therapy, or rehabilitation for medical or emotional problems? <i>(if yes, provide the nature of treatment and the name, address, and telephone of the provider)</i>	
Do you drink alcoholic beverages? <i>(if yes, how much and how often)</i>	
Do you smoke?	
Have you ever used illegal, controlled, dangerous substances?	
Have you ever undergone fertility testing?	

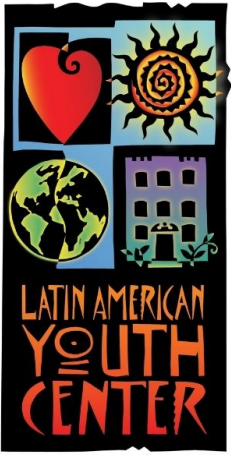
 SIGNATURE of Applicant

 DATE

**LATIN AMERICAN YOUTH CENTER
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APPLICANT MEDICAL REPORT

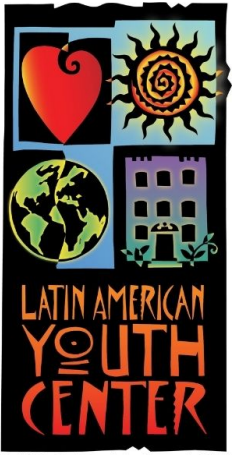
To be completed by the physician.



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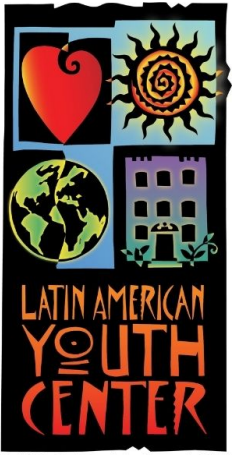
TO THE EXAMINING PHYSICIAN	The applicant below is considering the placement of a child in their home. LAYC, CFSA (Child and Family Services Agency), and the Department of Social Services in Maryland need information on his/her physical and mental health and the extent and significance of any health condition that may affect their ability to parent a foster/adoptive child.
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Full Name	
DOB	
How long has the physician known the applicant?	
Physical examination	Height:
	Weight:
	Temperature:
	Pulse:
	Blood Pressure:
	Respiration Rate:
	Vision:
	Hearing:
	Lungs:
	Heart:



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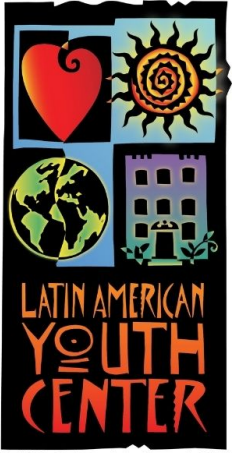
	Allergies:		
	Nervous system:		
	Endocrine:		
	List currently prescribed medications:		
Laboratory Tests <i>(Only one test is needed; either Tuberculin test OR Chest X-Ray)</i>	Tuberculin test <i>(Mantoux Method)</i>	Date:	Result:
	Chest X-Ray <i>(in a positive reactor)</i>	Date:	Result:
Reasons for childlessness, if applicable <i>(include prognosis, if known)</i>			
General health <i>(attach additional pages as needed)</i>			
Does the patient have the usual life expectancy?			
Does the patient have a contagious or infectious disease?			
Does the patient have a chronic disease or			



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<p>emotional condition that will affect the parenting of a foster child?</p>	
<p>Was any recommendation for medical or mental health care made to the patient? (if yes, explain)</p>	
<p>Does the patient have any substance abuse problems?</p>	
<p>Has the patient been treated or hospitalized for any of the following: (if yes, explain)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug/substance abuse <input type="checkbox"/> Bi-polar disorder <input type="checkbox"/> Psychosis <input type="checkbox"/> Other (explain)

<p>Recommendation:</p> <p>Based on this examination, the above patient is medically and emotionally fit to work with or provide care for children.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Make comments if applicable:</p>
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I have examined the above-named patient and certify that she/he is: (if you certify the following, please check both):

Free from disease in communicable form.

AND

In satisfactory physical condition, which will permit close association with children, without danger to them.

SIGNATURE of Physician or Nurse Practitioner

Physician or Nurse Practitioner Name

Address of Physician

Telephone

Date of Most Recent Physical Examination