1419 Columbia Road NW
Washington, DC 20009
Phone: 202.319.2225
Web: www.layc-dc.org

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.

Full Name	
Sex	☐ Male ☐ 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

If you have any questions regarding this request, please call the LAYC Esperanza Program at (202) 607-7622. Thanks!

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

_____ _____

SIGNATURE of Applicant DATE

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ESPERANZA PROGRAM

APPLICANT MEDICAL REPORT

To be completed by the physician.

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.

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 *(Only one test is needed; either Tuberculin test OR Chest X-Ray)*	Tuberculin test *(Mantoux Method)*	Date:	Result:
	Chest X-Ray *(in a positive reactor)*	Date:	Result:
Reasons for childlessness, if applicable (*include prognosis, if known*)			
General health (*attach additional pages as needed*)			
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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emotional condition that will affect the parenting of a foster child?	
Was any recommendation for medical or mental health care made to the patient? *(if yes, explain)*	
Does the patient have any substance abuse problems?	
Has the patient been treated or hospitalized for any of the following: *(if yes, explain)*	☐ Anxiety ☐ Depression ☐ Suicide attempts ☐ Alcoholism ☐ Drug/substance abuse ☐ Bi-polar disorder ☐ Psychosis ☐ Other (explain)

Recommendation: **Based on this examination, the above patient is medically and emotionally fit to work with or provide care for children.**	☐ Yes ☐ No Make comments if applicable:

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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