KLINGBERG
FAMILY CENTERS

Medical Information for Family Members

Authorization to Release Confidential Information

I, _____ hereby authorize _____ to release the information requested below to Klingberg Family Centers regarding myself and/or my minor children as part of our application to become a foster or adoptive family.

Date of Exam: _____

Patient Name: _____ Patient Date of Birth: _____

Please examine if there are any current concerns in the following areas:

Areas	Yes	No	Comments/Results (if yes)
Heart			
Lungs			
Hearing			
Neuro-Muscular			
Blood Pressure			
Speech			
Chest X-Ray (optional)			
Blood Serology (optional)			
Urinalysis (optional)			
Weight/Height			
Other (please specify)			

Current Medical Information

1. How long have your known the patient? _____

2. Please provide a list of all medications that the patient is currently taking and the reasons for each medication: _____
   _____
   _____

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3. Please provide your impression of the patient's physical health, emotional health, and general prognosis for continued well-being.
    - No concerns
    - Concerns (please specify) _____

4. Is this patient in good health and free of communicable disease?
    - Yes
    - No (please specify) _____

5. Do you consider there to be any physical or emotional barriers to this patient providing foster care or adopting a child at this time?
    - No
    - Yes (please specify) _____

Medical History

1. Did the patient ever have any significant chronic or active medical, familial, or psychiatric conditions?
    - No
    - Yes (please specify) _____

2. Has the patient had any significant hospital admissions?
    - No
    - Yes (please specify) _____

3. Does the patient have any history of alcohol or drug abuse?
    - No
    - Yes (please specify) _____

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____

Address: _____

Telephone: _____ Fax: _____