Florida Adoption Center LLC
Love Makes a Difference!

MEDICAL STATEMENT

MEDICAL FORM FOR CHILDREN CURRENTLY IN THE HOME

I, hereby give my authorization for my Physician to release the following information to the Agency Named above:

Signature of Parent _____ **Date**_____

Name of Child: _____ DOB: _____

To be completed by the physician:

Is this child regularly treated by you? Yes [ ] No [ ]

If Yes, what medical services have you provided?_____

_____

_____

Does this child have any serious physical or emotional disorders or any major medical concerns? Yes [ ] No [ ]

If Yes, please explain:_____

_____

_____

Immunizations: Up to Date: Yes [ ] No [ ] Needs: _____

_____ _____ _____
Physician's Printed Name Physician's Signature License number

_____
Address

_____
City ST Zip Code

_____ Office Stamp_____
Telephone

Date _____

1600 Sarno Rd, #8, Melbourne, FL 32935. Tel: 321 250 5683
Website: http://www.floridaadoptioncenter.com