Florida Adoption Center LLC

Love Makes a Difference!

MEDICAL REPORT FORM

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 physical or emotional disorders or any major medical concerns? [ ] Yes [ ] No

If Yes, please explain? _____

_____

_____

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

_____ _____ _____ Physician's Lic. # _____

Physician's Printed Name Signature

Office Stamp_____

Facility Name: _____ Date _____

Address: _____

Phone: _____

Fax: _____

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