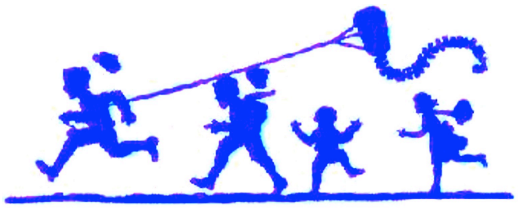

Friday's Child Adoption Services, Inc.
A Virginia Licensed Child Placing Agency

Report of Medical Examination
Date_____

Patients Name_____Birth Date_____

Address_____City_____State_____Zip_____

I, _____ M.D. have examined the above named patient

and find him/her to be in _____ health. Based upon my examination of the patient,

CIRCLE ONE: ***I find/ do not find (circle one)*** evidence of any medical condition or mental health concern that would in any way impair his/her ability to adopt or to subsequently rear and care for the child.

CIRCLE ONE: The patient's life expectancy should be ***normal/reduced (circle one)***. I find/do not find any evidence of a history of substance abuse or mental illness.

The following tests were administered (if indicated): Results/Date

1. _____ _____

2. _____ _____

3. _____ _____

The following medications were prescribed:

1. _____

2. _____

Physician Signature_____Printed Name_____

Physician Address_____

City_____State_____Zip_____