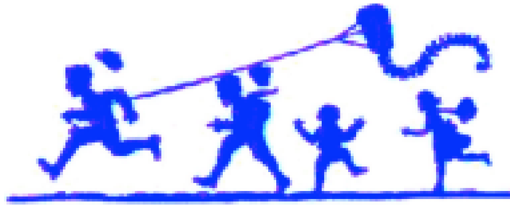

Friday's Child Adoption Services, Inc.
A Virginia Licensed Child Placing Agency

Adult Report of Medical Examination

Patients Name____ DOB:_____________

Address______________________________City____________________State_________Zip____

I, ____________________________________ (please print) MD/DO/NP (Please circle) Other: ________

have examined the above named patient and find him/her to be in **Excellent/Good/Fair/Poor (circle one)**

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 an adopted child.

CIRCLE ONE: The patient's life expectancy should be **normal/reduced (circle one)**. **I find/do not find (circle one)** any evidence of a history of substance abuse or mental illness. ***If yes, please provide an explanation and/or recommendation:***

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

1.

2.

The following medications were prescribed:

1.

2.

Physician Signature____________________________________ Date: ____________________

Physician Address____

City_____________________________State______________________Zip____________