South Carolina Department of Social Services

MEDICAL STATEMENT FOR HOUSEHOLD MEMBERS

To be completed by a Licensed Medical Practitioner, for the purpose of evaluating the health of household members of a prospective foster/adoptive family.

Name of Household Member: ______________________________

Relationship to Applicant: ______________________________

I give permission for ______________________________ to share information about me
Name of Licensed Medical Practitioner

with the Department of Social Services, for the purpose of completing a foster/adoptive home study.

______________________________ ______________
Signature of Household Member/Parent Date

Does the household member have any contagious or communicable diseases? If so, please describe.

____

____

TB Test: (Date and finding) ______________________________

Does the household member have any health concerns that would affect or limit the family's ability to care for a child? If so, please describe.

____

____

____

Do you have any other concerns related to the placement of a child in the home? If so, please describe.

____

____

____

Completed by:

______________________________ ______________
Licensed Medical Practitioner Date

Please print/type name and address of Licensed Medical Practitioner:

____

____

____

Please return form to: ______________________________

____

____

____