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.

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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.

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

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Completed by:

____________________ Licensed Medical Practitioner

____________________ Date

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

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Please return form to: ____________________

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