South Carolina Department of Social Services

MEDICAL STATEMENT FOR CHILD

Reset

Name of Child: _____ Date of Birth: _____

I give permission for _____ to share information about my child with the
(Name of Licensed Medical Practitioner)
Department of Social Services for the purpose of a foster/adoptive home study.

Signature of Parent(s): _____ Date: _____

Comprehensive Health and Developmental History: (Document any known chronic health problems, medications, allergies, significant acute illnesses and prenatal history of the child.)

Are immunizations up to date? _____ If not, which immunizations are needed? _____

Immunizations administered at: _____

Physical Assessment:

Height: _____ Weight: _____ Blood Pressure: (Over age 3) _____ Temperature: _____

Assessment of Nutritional Adequacy and Overall Well-Being:

Behavior/Developmental Assessment: (include an assessment of behavior, language, social and psychomotor skills)

Significant Findings/Recommendations:

Licensed Medical Practitioner's Signature: _____ Date: _____

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

Please return form to: