Tennessee Department of Children's Services

Foster Parent/Other Adult Medical Report

☐ Foster Parent ☐ Other Household Adult

First Name	***Last Name***

To be completed by Foster Parent or Other Household Adult:

SMOKING

Do you smoke? ☐ Yes ☐ No Number/packs of cigarettes per day _____

Do you drink alcohol? ☐ Yes ☐ No Frequency and amount: _____

MEDICAL

Primary Care Provider _____ Date of last physical _____

Current Specialists (list types and dates of last visits):

Special needs or disabilities

Current Medical Problem _____

Current Medications _____

Date of Last Influenza Immunization _____

Pertussis Vaccine Date (Adult Inoculation) _____

MENTAL HEALTH

Have you ever been treated or hospitalized for a mental illness or suicide thoughts/attempts? ☐ Yes ☐ No

If yes, list physician, dates and treatment:

To be completed by medical professional:

TB Risk Assessment Date/Results: _____

and/or ☐ TB (PPD) Date/Results: _____

or ☐ Not at Risk ☐ Low Risk

Specify any physical, mental, or emotional problems which would affect this person's ability to care for a child. If the person is identified as other adult living in the home, indicate conditions detrimental to a child's placement in the home.

☐ I recommend ☐ do not recommend this person as a foster or adoptive parent for children.

Physician/NP/PA Print Name _____

☐ *I am not the primary care provider for this individual and am completing this form based on a single exam in combination with the information provided by the individual the day of the exam.*

Physician/NP/PA Signature _____ **Date** _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Foster Home Case Record