CFS 604
Rev. 8/2020

Form Distribution
Licensing worker/supervisor
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STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
Medical Evaluation of an Adult in a Foster or Adoptive Home

Name of Person Examined: _____ Date: _____

Date of Birth: _____ How long have you been treating this patient? _____

This form will aid the Department in determining the physical wellness and capabilities of adults in foster or adoptive homes who are or may be caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and for the foreseeable future (five to ten years).

I. HISTORY

1. Check any health problems:

☐ Heart Problems	☐ Arthritis	☐ Depression	☐ Tremors
☐ Lung Problems	☐ Obesity	☐ Sleep Disorder	☐ Hepatitis
☐ Diabetes	☐ Poor Ambulation	☐ Confusion	☐ Allergies
☐ High Blood Pressure	☐ Weak/Frail	☐ Dementia	
☐ Asthma	☐ Vision	☐ Epilepsy/Seizures	
☐ Kidney Disease	☐ Hearing	☐ Strokes/Paralysis	

Explain ***all*** medical condition(s) checked and any other chronic conditions:

_____

_____

_____

2. Are there any condition(s) that are progressive in nature? Yes ☐ No ☐
If yes, explain: _____

_____

_____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ☐ 5 years, ☐ 10 years ☐ 15 years? If yes, explain: _____

_____

_____

4. Medication(s): _____

_____

_____

Are there any physical limitations as a result of medication(s)? Yes ☐ No ☐
If yes, explain: _____

_____

_____

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits
Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol ☐ _____ Drugs ☐ _____

Tobacco ☐ _____ Other ☐ _____

6. Date _____ Result of Tuberculin Test (initial exam only): _____

7. Date _____ Result of Chest X-Ray (if necessary): _____

II. IMMUNIZATIONS

Has the patient received the following immunization?

Tdap: YES _____ Date Received: _____ NO _____ Reason: _____

Has the patient received a flu vaccination over the past year?

YES - Date Received _____ NO – Reason: _____

III. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

_____

_____

_____

_____

_____

IV. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:
   Under 6 months Yes ☐ No ☐
   6 months to 3 years Yes ☐ No ☐
2. Walk/maneuver 50-100 feet without major difficulties: Yes ☐ No ☐
3. Bend/stoop, kneel, reach: Yes ☐ No ☐
4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes ☐ No ☐
   If Yes, what type? _____
5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Lift from a bed to chair, etc.	Yes ☐	No ☐	Don't Know ☐
Frequent Feedings	Yes ☐	No ☐	Don't Know ☐
Frequent Suctions	Yes ☐	No ☐	Don't Know ☐
Frequent Monitoring	Yes ☐	No ☐	Don't Know ☐
Frequent Medication	Yes ☐	No ☐	Don't Know ☐
Frequent Nebulizations	Yes ☐	No ☐	Don't Know ☐
Frequent Treatments	Yes ☐	No ☐	Don't Know ☐

Are any limiting conditions temporary? Yes ☐ No ☐

If yes, which condition(s): _____

For each condition, how long will the limitation exist? _____

I certify that this individual is found free from symptoms of communicable disease.

Yes ☐ No ☐ If No, explain: _____

_____

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes ☐ No ☐ If No, explain: _____

_____

Physician's Signature: _____ Date: _____

State License Number: _____

Address: _____

Telephone: _____