PHYSICIAN'S REPORT FOR A CHILD

6th Judicial Circuit-Family Division Oakland County
Adoption Services
1200 North Telegraph Road
Pontiac, Michigan 48341

Re: _____
DOB: _____

Dear Dr. _____ ,

I hereby authorize you to release to Oakland County Adoption Services information regarding my current and past physical and mental health.

Sincerely, _____

TO BE COMPLETED BY THE PHYSICIAN

Date of physical examination _____ Length of time know to physician _____

Diseases or illnesses known or treated by you in the last five years: _____

CURRENT HEALTH STATUS:

Height _____ Weight _____

Medications currently prescribed; dosage and purpose: _____

ANY HISTORY OF:

Allergies _____ Asthma _____
Other _____

Childhood Diseases: _____
Hospitalizations, operations, or injuries: _____
HIV information (optional): _____

IMMUNIZATIONS	**DATES OF ORIGINAL SERIES**			**BOOSTERS**
DPT				
Polio				
MMR				
HIB				
Hepatitis B				
Chicken Pox				

Remarks on medical examination (**on the basis of the medial history and present physical condition, please state any medical concerns you may have regarding this child**): _____

Would you like to discuss this information with a Social Worker: Yes _____ No _____

PLEASE PRINT OR TYPE

Physician's Name _____ **PHYSICIAN'S SIGNATURE** _____

Address

City, State, Zip Code Telephone Number