PHYSICIAN'S REPORT FOR AN INFANT UNDER THE AGE OF ONE YEAR

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

BIRTH HISTORY INFORMATION

Weight	_____	Height	_____
Head Circumference	_____	Chest Circumference	_____
Results of PKU Test	_____	APGAR Source	_____

Complications at Birth: _____
Abnormalities Noted at Birth: _____

CURRENT HEALTH STATUS

Weight	_____	Height	_____
Head Circumference	_____	Chest Circumference	_____
Head, Neck	_____	Skin (rash, birth marks)	_____
Eyes	_____	Ears	_____
Nose	_____	Mouth	_____
Lungs	_____	Heart	_____
Abdomen	_____	Genitals	_____
Extremities	_____	Reflexes	_____

Formula and Diet: _____
HIV Information (Optional): _____
Immunizations: _____
Medications Prescribed: _____
Remarks on Medical Examination: _____

PLEASE PRINT OR TYPE

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

_____
Address

_____ _____
City, State, Zip Code Telephone Number **DATE OF EXAMINATION**