Tennessee Baptist Children's Homes, Inc.

Fax Number – 615-377-8521

CONFIDENTIAL INFORMATION

Please notify the Human Resource office at

615-376-3164

that confidential information has been sent.

Tennessee Department of Children's Services

Resource Parent Medical Report

Last Name	First Name	Middle Name or Initial

Date of Birth	SS#	Sex	Race
	- -	☐ Male ☐ Female	

Street Address	City	State	Zip Code

Language Spoken in the Home	

A complete family health history and current physical examination are required as an essential part of the evaluation of a family for the placement of a child.

Special Needs or Disabilities _____

Current Medications & Dosage *(List all prescription and over-the-counter medications you are currently taking)*

_____

Allergies (medication, food, insect stings, etc) ☐ Yes ☐ No

Specify _____

Special Diet _____

FAMILY HEALTH HISTORY *(Please check appropriate box of family member for all that apply)*

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease/heart attack	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Blood/circulatory problems	☐	☐	☐	☐	☐	☐
Sickle cell disease/trait	☐	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Hepatitis/liver disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Bone/joint disorder	☐	☐	☐	☐	☐	☐
Infectious disease	☐	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐	☐
Alcohol/drug use	☐	☐	☐	☐	☐	☐
Mental illness (list type)	☐	☐	☐	☐	☐	☐
Other Medical Conditions	☐	☐	☐	☐	☐	☐

Explain any checked items _____

Name and ages of children

Are parents, siblings & children living ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Name, age at death and cause of death _____

_____

Please disregard all previous versions prior to the date listed below. Always check "Forms" Website for most current version.

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Last Name _____ **First Name** _____ **Mid. Int.** _____

Medical
Do you have a regular medical provider ☐ Yes ☐ No
If yes, name of medical provider Date of last visit

MENTAL HEALTH
Have you ever been treated or hospitalized for a mental illness or suicide thoughts/attempt ☐ Yes ☐ No
If yes, list dates and hospital
Have you had a psychological evaluation ☐ Yes ☐ No
If yes, list date and provider

Alcohol/Drug History And Frequency

☐ Alcohol _____ ☐ Hallucinogens _____
☐ Marijuana _____ ☐ Sedatives _____
☐ Barbiturates _____ ☐ Steroids _____
☐ Amphetamines _____ ☐ Tobacco _____
☐ Huffing _____ ☐ Other _____

Physical Exam (To be Completed by the Physician)

Height _____ **Weight** _____ **BMI** _____ **Temp** _____ **Resp** _____ **B/P** _____

Vision Right: 20/_____ Left: 20/_____ **Hearing** Right: ☐Pass ☐Fail Left: ☐Pass ☐Fail

Current Problems _____

Unclothed Physical Exam ☐ Partial ☐ Complete

	Normal	Abnormal	Comments
General Appearance Nutrition, activity level, hygiene, emotion, behavior	☐	☐	
Skin - color, scars, eruptions, piercings, tattoos	☐	☐	
Head - scalp, hair loss, injury	☐	☐	
Eyes - redness, discharge, pupils	☐	☐	
Ears - hearing, TMs, canals, foreign bodies	☐	☐	
Nose - congestion, noisy breathing, discharge	☐	☐	
Mouth/Throat - palate, teeth, gums, mouth breathing	☐	☐	
Neck - stiffness, thyroid	☐	☐	
Lymph nodes/Glands - swelling, tenderness	☐	☐	
Lungs/Chest - breath sounds, nipples	☐	☐	
Heart/Circulatory - rate, rhythm, murmur	☐	☐	
Abdomen - masses, tenderness	☐	☐	
Genitourinary M: circumcision, testes, meatus, hernia, discharge F: swelling, discharge, lesions	☐	☐	
Musculoskeletal - ROM, gait, coordination, scoliosis	☐	☐	
Neurological - tremors, seizures, headaches	☐	☐	
Rectal exam	☐	☐	
Pelvic exam	☐	☐	

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Last Name _____ **First Name** _____ **Mid. Int.** _____

TB Assessment Date/Results _____ **OR** ☐ **TB (PPD)** Date/Results _____

☐ **CBC** ☐ **Metabolic Panel** ☐ **Cholesterol** ☐ **Urine Analysis** ☐ **VDRL/GC/Chlamydia** ☐ **Other** _____

Applicant is free of communicable disease ☐ **Yes** ☐ **No** **Explain if no** _____

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.

On the basis of this examination and my knowledge of this patient, I recommend	☐	do not recommend	☐
this person as a resource or adoptive parent for children.			
Comments:			

Physician name _____

Physician Signature _____ **Date** _____

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