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

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: ____