



**MEDICAL FORM**

\_\_\_\_\_  
 Applicant's full name Date of Exam

Applicant's Height: \_\_\_\_\_ Applicant's Weight: \_\_\_\_\_

\_\_\_\_\_ Is currently in good health, is free of all communicable diseases, and is mentally and physically capable of raising an adopted child. The applicant has a normal life expectancy and does not have a chemical or alcohol dependency.

\_\_\_\_\_  
 Physician's Signature Date Signed

\_\_\_\_\_  
 Physician's Printed Name License Number

\_\_\_\_\_  
 Physician's full address and telephone number