

**PHYSICIAN'S STATEMENT FOR VOLUNTARY SERVICES/PROBATE APPLICANT**

<b>AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION</b>	
I hereby authorize _____, MD to release to the Department of Children and Families the information requested below regarding myself or my minor children, as required by the Department regulations for Voluntary Services/Probate applicants and their children.	
SIGNATURE OF APPLICANT	DATE
ADDRESS, NO. AND STREET	CITY, STATE, ZIP

APPLICANT'S (OR CHILD'S) NAME			DATE OF BIRTH		DATE OF LAST EXAMINATION	
WEIGHT	HEIGHT	EYES	HEARING	NEURO-MUSCULAR	BLOOD PRESSURE	
HEART			LUNGS			
CHEST X-RAY		DATE	RESULTS			
BLOOD SEROLOGY		DATE	RESULTS			
URINALYSIS		DATE	FINDINGS			

How long have you known the applicant (or child)?

Has the applicant (or child) had any significant chronic or active medical, familial or psychiatric conditions?

Yes  No If any, describe:

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Has the applicant (or child) had any significant hospital admissions?

Yes  No

If yes, list with dates, diagnoses, treatment and results:

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Please give your impression of the applicant's (or child's) health status, both physical and emotional; general prognosis for continued well being:

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Do you consider the applicant's physical and emotional condition satisfactory to provide care for a child?

Yes     No

If no, please comment:

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Is the applicant (or child) free from communicable disease?     Yes     No

If no, please comment:

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NAME OF PHYSICIAN		SIGNATURE	
ADDRESS		TELEPHONE NUMBER	DATE

**NOTE:** *This report should be mailed directly by the examining physician to the Department of Children and Families office listed below:*

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Attention: 

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