Faith International Adoptions
www.faithadopt.org

Declaration of Health Status

Revised March 2012

To Examining Physician: Your medical report is of paramount importance to the Foreign Adoption Authority in its examination of the adoption qualification of the adopters. You are kindly requested to **legibly fill in all the blanks**. Any blank fields may result in a delay in the family adoption process. Thank you!

Name or Prospective Adoptive Parent: ______________________________ Date of birth: ________________

Medical History

Have you ever had…

Tuberculosis	☐ No	☐ Yes	Mental Disease	☐ No	☐ Yes
Tumor	☐ No	☐ Yes	Other Communicable Disease	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Alcoholism or Abuse of Substance	☐ No	☐ Yes
Liver Disease	☐ No	☐ Yes	Any Genetic Disease	☐ No	☐ Yes
Sexual Disease	☐ No	☐ Yes	Any Major Surgeries	☐ No	☐ Yes
Neuropathy	☐ No	☐ Yes			

Blood Test (results will expire after 12 months of test day)

Date of test *(mm/dd/yyyy)*: _________________ Result: ☐ Normal ☐ Abnormal

Routine Blood Test: ☐ Negative ☐ Positive HbsAg: ☐ Normal ☐ Abnormal

Liver Function: ☐ Normal ☐ Abnormal

Urinalysis (results will expire after 12 months of test day)

Date of test *(mm/dd/yyyy)*: _________________ Result: ☐ Normal ☐ Abnormal

HIV Test (results will expire after 12 months of test day)

Date of test *(mm/dd/yyyy)*: _________________ Result: ☐ Normal ☐ Abnormal

Is the patient taking any medication? ☐ No ☐ Yes

If "Yes", please provide name of medication and purpose ____

Are there any physical, mental or psychological unfavorable elements of the adoption applicant, which will affect the upbringing of the child? ☐ Yes ☐ No

Is the adoption applicant's state of health suitable for raising a child? ☐ Yes ☐ No

Certified of Examining Physician

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SIGNATURE FULL NAME MD LICENSE DATE

Subscribed and Sworn before me this _______ day of ________, 20___

Resident of State: ___________________ County: ______________

Name: _________________ My commission expires: ______________

Signature: ____