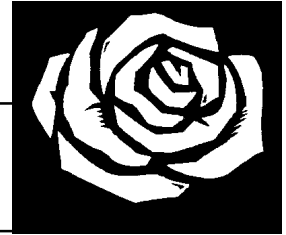


A Center for Adoption Services



602 Alder Avenue N.E.
Bainbridge Island, WA 98110
Web: www.edopt.net

Phone: 206-780-1972
Fax: 206-780-1817
Email: adoption@edopt.net

Adoptive Applicant Medical Report (CONFIDENTIAL)

Name of Physician: _____ Date: _____

Address of Physician: _____

Please return to: A Center for Adoption Services, 602 Alder Ave NE, Bainbridge Is, WA, 98110 — Tel 206.780.1972, Fax 206.780.1817

A Center for Adoption Services requests a medical report on _____
We need to know if this person has any chronic, contagious or disabling illness that would interfere with the proper care of a child or children.

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____

Vision: Left _____ Right: _____ Hearing: Left _____ Right: _____

Routine Blood Test: Normal / Abnormal Routine Urine Test: Normal / Abnormal

HIV Test: Date of Test _____ Negative / Positive

Is the patient taking any medication? For what purpose?

Significant Past Medical History:

Current Medical Diagnosis:

Prognosis:

Comments or Impressions:

Are there any physical, mental or psychological unfavorable elements of the adoption applicant, which would affect the upbringing of a child?

Is the adoption applicant's state of health suitable for raising a child?

Physician's Signature: _____ Date: _____

Print Name of Physician: _____

I authorize my physician to release information to A Center for Adoption Services.

Adoptive Applicant's Signature

Date