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Physician's Statement Form

Foster/Adoptive Parent's Name:

Address:

Date of Birth:

Note to physician: The person identified above has applied to become a foster/adoptive parent with Buckner Children and Family Services. Our agency serves children who come from chaotic abuse and neglect backgrounds and who may exhibit pronounced emotional and behavioral problems.

As part of the application process, we require applicants to obtain a physician's statement certifying that he/she meets the following criteria.

1. Is considered free of communicable of infectious disease;
2. Has no known physical or mental condition which would be hazardous to, or impact negatively a child placed in their home.
3. Is considered able to accept responsibility for a foster/adoptive child without risking his/her own health.

History of significant medical problems (including diagnosis, prognosis, and any effect on life expectancy). Please include separate statement or relevant medical records if necessary.

_____
_____
_____
_____
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Physician's statement: Based on my knowledge of this patient, I find that he/she is physically and mentally capable to be verified as a foster/adoptive parent and meets the criteria above. Comments:

_____

_____

Physician's Name (Print)	
Physician's Signature	
Physician's Address	
Phone	

Thank you for your assistance. Please return form to: Buckner Children and Family Services.