FAMILY SERVICES

Physician's Statement Form

Foster/Adoptive Parent's Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

This person has applied to become a foster/adoptive parent with CK Family Services, a role in which they would be responsible to care for children who come from chaotic backgrounds of abuse and neglect and who may have profound emotional and/or behavioral problems.

In order to be verified as a foster/adoptive parent, each applicant must be evaluated to ensure that s/he is physically and mentally healthy and able to accept responsibility for a foster/adoptive child without risking his/her own health.

Chronic significant diagnoses requiring treatment: _____

_____

_____

In your professional medical opinion, would you be able to confidently expect for the applicant to be able to participate in raising children in a stable and consistent environment to adulthood?

☐ Yes ☐ No If no, please explain: _____

_____

Does this person have any condition which would make it difficult for them to play with a child on the floor; lift or carry a child; spend time outside with a child; attend regular school activities; and/or attend to the daily living skills of a child?

☐ Yes ☐ No If yes, please explain: _____

_____

Based on your knowledge of this person, do you believe that s/he is physically and mentally capable to be verified as a foster/adoptive parent?

☐ Yes ☐ No If no, please explain: _____

_____

Physician's Name (print): _____

Physician's Signature: _____ **Date:** _____

Phone: _____

Return completed form to CK Family Services via fax 817-516-9102 or email preservice@ckfamilyservices.org.
Thank you for your assistance!

Revised 06.23.2016