

# MEDICAL REPORT ON PROPOSED ADOPTER

**Confidential: Please mail (postal/courier) or hand deliver original completed documents to the Child Development Agency**

NAME: ..... AGE: .....  
(Surname) (Christian names)

ADDRESS: ..... OCCUPATION: .....

DATE OF APPEARANCE AND EXAMINATION: .....

HAS HE/SHE SUFFERED AT ANY TIME FROM:

FITS OF ANY KIND: .....

TUBERCULOSIS: ..... ANY NERVOUS OR MENTAL DISORDER: .....

IS THERE ANY RELEVANT FAMILY HISTORY OF MENTAL OR PHYSICAL DISEASE? .....

IS THERE ANY DETECTABLE ABNORMALITY IN: (if yes give particulars)

CARDIO-VASCULAR SYSTEM: .....  
(Including blood pressure)

RESPIRATORY SYSTEM: .....  
(Including chest x-ray if necessary)

GENITO-URINARY SYSTEM: .....  
(Including urine test for sugar and albumen)

ALIMENTARY SYSTEM: .....

CENTRAL NERVOUS SYSTEM .....

SKIN: ..... EYES: .....

EARS: ..... HEARING: .....

IS HE/SHE IN GOOD HEALTH? .....

GIVE YOUR GENERAL OPINION OF HIS/HER:

PHYSIQUE: .....

MENTAL AND EMOTIONAL STABILITY: .....

PSYCHOLOGICAL SUITABILITY TO ADOPT A CHILD: .....

IN YOUR PROFESSIONAL OPINION IS THERE ANY REASON TO EXPECT THAT THE EXAMINEE'S HEALTH MAY DETERIORATE BEFORE THE CHILD HAS REACHED THE AGE OF INDEPENDENCE? .....

NAME: ..... SIGNATURE: .....  
Medical Examiner

QUALIFICATION: .....

ADDRESS: ..... DATE .....