Maryland
DEPARTMENT OF HUMAN SERVICES

Medical Form for Resource Parents and Household Members 18 and Older

The purpose of this form is to obtain information about the individual's health to assess the impact it may have on a child in out-of-home care

Full Name:	
Date of Birth:	
Date of Exam:	
Name of Healthcare Practitioner:	
Signature of Healthcare Practitioner:	
Healthcare Practitioner's Phone Number and Address:	

Physical Health, Mental Health and Substance Use
Please describe the individual's general health.
Does the individual have any communicable diseases? ☐Yes ☐No If yes, please describe.

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Does the individual have any medical or mental health diagnoses? ☐Yes ☐No If yes, please describe.
Has the individual been treated for any medical or mental health conditions or a substance use disorder? ☐Yes ☐No If yes, please describe.

Current Prescription and Over-the-Counter Medications	
Name of medication(s)	Purpose of medication

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Vaccinations

Date of most recent Pertussis vaccination (required for resource parents caring for children under the age of 1): _____

Date the next Pertussis vaccination due: _____

Risk of Tuberculosis

Based on a tuberculosis assessment, is a tuberculosis test recommended due to high risk? ☐ Yes ☐ No
If yes, please note the date of Tuberculosis test and the results.

Treatment Recommendations

Have any treatment or follow-up recommendations been made to the individual? ☐ Yes ☐ No If yes, please describe.

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Treatment by Specialists
Is the individual treated by a specialist for any medical or mental health reasons? ☐Yes ☐No If yes, please describe.

Additional Comments
Please share any additional pertinent information.