



10 West 7<sup>th</sup> Street, Suite F, Eureka, CA 95501  
 PH: (707) 444-9909 / FAX: (707) 442-6672  
 www.adoption-horizons.org

**MEDICAL CERTIFICATION**  
**Child in the Home**  
*(Parent to complete shaded areas)*

I hereby authorize \_\_\_\_\_ to release the medical information contained on this form to **Adoption Horizons** for the purpose of investigating the adoptive placement of a child.

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**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

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**Address** \_\_\_\_\_

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**Phone Number** \_\_\_\_\_ **Parent's Signature** \_\_\_\_\_

Dear Physician,

The above patient of yours is a member of a family which is pursuing the adoption of a child through **Adoption Horizons**. A medical examination report is required from this agency. Additionally, the health information which you provide will assist us in the preparation of this family for an adoptive child. Thank you for your assistance. Should you wish to make further comments regarding this patient, please contact our office at (707) 444-9909.

**I. INFORMATION ABOUT THE CHILD**

Height: \_\_\_\_\_ ft \_\_\_\_\_ in      Weight: \_\_\_\_\_ lbs      Date of Last Exam: \_\_\_\_\_

Immunizations up to date:       Yes       No

Does this child have any special needs?       Yes       No

If yes, please explain: \_\_\_\_\_

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Does this child have any other medical condition that require medical attention:       Yes       No

If yes, please explain: \_\_\_\_\_

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Based on your history with this family, would you recommend that they adopt?       Yes       No

**II. CERTIFICATE OF EXAMINATION**

I certify that I have found this child to be in \_\_\_\_\_ health and free from all communicable diseases. (excellent, good, fair, poor)

I cannot sign the above certificate for the following reasons:

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF DOCTOR	DATE EXAMINED
PRINTED NAME OF DOCTOR	MEDICAL LICENSE #
ADDRESS & PHONE NUMBER	OFFICE STAMP