KEMP COUNSELING AND CONSULTING SERVICES
Northeast Florida Adoption Support
Dr. Shawna Kemp Haley, Ed.D, LCSW
Carissa Heck, MSW, LCSW

MEDICAL STATEMENT

(To be completed by physician)
(Examination must not be performed by a relative of the patient)

Patient's Name: _____ Date of Birth: _____

Height:_____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: _____ Hearing: _____

Heart: _____ Lungs: _____

Skin: _____ Orthopedic Defects: _____

Teeth: _____ Endocrine System: _____

Abdomen: _____Nervous System: _____

Allergies: _____ Cancer: _____

Mental Illness: _____ Surgeries: _____

Chronic Condition: _____ Other: _____

Tuberculin Test: Date: _____ Results: _____

Chest x-rays (required if TB is positive): _____

Fertility Status: _____

Pap smear: _____

Length of time patient has received care from you and follow-up plan, if any: _____
_____

Is the patient in overall good health at the present time? _____

In your opinion does the patient have normal life expectancy? _____

Could you add anything related to the personality, physical condition or past health history, not already explained which would affect the patient's ability to take on the responsibilities of parenthood? _____
_____
_____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Address: _____

Telephone: _____