

**PHYSICIAN'S REPORT ON
PHYSICAL HEALTH OF APPLICANT**



INSTRUCTIONS

Physician: Please complete the following form for the person referred to as "applicant" and mail to:

ATTN: Kathryn Feiertag
Lutheran Counseling & Family Services
3800 N. Mayfair Road
Wauwatosa, WI 53222

Applicant: Please print and sign your name as proof that you consent to your physician sending this completed form to LCFS.

Print Name: _____

Signature: _____

CURRENT HEALTH STATUS

Date of Exam: _____ Length of Time Known to Physician: _____

General Appearance: _____

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

Heart: _____ Lungs: _____

Abdomen: _____ Extremities: _____

Hearing: _____ Vision: _____

Mouth & Pharynx: _____ Thyroid: _____

LABORATORY TESTS

TB test and/or X-ray Date: _____ Results: _____

Urinalysis Date: _____ Results: _____

Hemoglobin Date: _____ Results: _____

ANY HISTORY OF:

Substance Dependency: _____ Diabetes: _____

Cardiac Disease: _____ Cancer: _____

Mental Illness: _____ STDs: _____

Neurological Disorders: _____ Tuberculosis: _____

ADDITIONAL INFORMATION

Diseases, injuries, surgeries, disabilities, or medical conditions not referred to above: _____

Medication currently prescribed; dosage and purpose: _____

Based upon a medical examination performed within the previous six months, does this person have any illness or disability that is likely to threaten the health of children or interfere with the person's capacity to provide care? Yes No

SIGNATURE

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____

Address: _____