WASHTENAW COUNTY TRIAL COURT
ADOPTION UNIT

INFANT/CHILD MEDICAL REPORT

Child's Name:	Date of Birth:
I authorize *(name of health care provider)* to release and exchange medical information to the Adoption staff at the Washtenaw County Juvenile Court – Family Division – Adoption Unit for the purpose of completing an adoption investigation.	
Signature of Patient's Parent/Guardian/Caretaker	Date:

To the Health Care Provider:
Prior to approval for adoption, the physical and mental health of the child to be adopted must be assessed to determine the health of the child and the degree that the health or safety of the child and the quality of his/her care must not be adversely affected by the adoption. To assist in this matter, please complete this form based upon the information gathered during a recent exam with the above-named child. If you wish to discuss the contents of this report, you may call the Adoption Specialist at (734) 222-6938. If there is no need to discuss the report, please return it to the child's parent/guardian.

Date of Exam:	How long have you known this patient?:	
Age at Visit:	Present Height:	Weight:
Reason for Visit: ☐ Well child check-up	☐ Immunizations	☐ Other:
General Appearance: ☐ Within Normal Limits	☐ Other:	
Motor Development: ☐ Within Normal Limits	☐ Other:	
Intellectual Development: ☐ Within Normal Limits	☐ Other:	
Any Communicable Diseases: ☐ No	☐ Yes:	
Any Chronic Illnesses/Diseases: ☐ No	☐ Yes:	
Immunizations Up-to-Date?: ☐ Yes	☐ No:	
Return Visit Necessary:		

☐ No	☐ Yes:
If the exam is not within normal limits, please list recommendations:	
Comments:	

Health Care Provider Printed Name:		
Health Care Provider Signature:		Date:
Address:		
City:	Zip:	Telephone: