Name of Adoptive Parent DOB
 (First) (Middle) (Last)

Street Address City Zip Code County

**TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:**

Sign one of the statements below (1 OR 2):

1. I do not find evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments Date (MM/DD/YYYY)

1. I found evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments Date (MM/DD/YYYY)

