## State of Kansas Department for Children and Families Prevention and Protection Services

## Adoption Health Statement

PPS 5317 July 19 Page **1** of **1** 

Name of Adoptive Parent				DOB	
	(First)	(Middle)	(Last)		
Street Address		City	Zip Code	County	
TO BE COMPLETED	BY LICENSED PHYSICIA	N, OR NURSE TRAII	NED TO PERFORM HEA	ALTH ASSESSMENTS:	
Sign one of the sta	tements below (1 OR 2):				
I do not find ev     welfare of child		ental illness that wo	uld conflict with the a	bility to care for the health, safety o	
Signature of Licensed Physician or Nurse trained to perform health assessments				Date (MM/DD/YYYY)	
I found evidend     welfare of child		illness that would c	onflict with the ability	to care for the health, safety or	
Signature of Licens	ed Physician or Nurse tr	ained to perform he	palth accessments	Date (MM/DD/YYYY)	

