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

PPS 5317 -A
Revised April 2026

Adoption Health Statement

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)

2. 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)