Department of Children and Families
PHYSICIAN'S STATEMENT FOR VOLUNTARY SERVICES/PROBATE APPLICANT
DCF-Probate-357
3/16 (Rev.)

AUTHORIZATION TO RELEASE CONDIENTIAL INFORMATION

I hereby authorize _____ MD., To release to the Department of Children and Families The information requested below regarding myself or my minor child as required by the Department Regulations for Voluntary Services / Probate applicants and their child(ren).

Name of Applicant or Child:					
Signature of Applicant:				Date:	
Address: (No. and Street)		City		State	Zip
Applicant / or Child's Name:			DOB:	Date of Last Examination:	
Weight:	Height:	Eyes:	Hearing:	Blood Pressure:	
Heart:		Date:	Lungs:	Neuro-Muscular:	
Chest X-Ray:		Date:	Results		
Blood Serology:		Date:	Results		
Urinalysis:		Date:	Results		

How long have you known the applicant (or Child)?:

Has the applicant (or child) had any significant chronic or active medical, familial or psychiatric conditions?
☐ Yes ☐ No. If "Yes", please describe:

Has the applicant (or child) had any significant hospital admissions?
☐ Yes ☐ No. If "Yes", please describe:

Please give your impression of the applicant's (or child's) health status, both physical and emotional; general prognosis for continued well-being:

Do you consider the applicant's physical and emotional condition satisfactory to provide care for a child?:
☐ Yes ☐ No. If "No", please describe:

Is the applicant (or child) free from communicable disease?
☐ Yes ☐ No. If "No", please describe:

Name of Physician			Signature of Physician		
Address:	City	State	Zip	Phone:	Date:

NOTE: This report should be mailed directly by the examining physician to the Department of Children and Families office listed below:

Attention:	
DCF Office and Address: Please Select DCF Office	Date: