Sierra Vista Child & Family Services

RFA/Adoptive Health Screening Questionnaire

Patient's Name _____ DOB _____

1. Is there any related medical condition that would impair this patient's ability to provide for a foster child's permanency, safety and well-being?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

2. From a medical viewpoint, is there anything that would impair this person's ability to adopt and raise a child?

- ☐ Yes
- ☐ No

Please use this space for any additional comments you feel may be pertinent to this patient/case.

_____

Date Examined	Signature of Doctor
Address of Doctor	
Telephone Number	Printed Name of Doctor