ST. ELIZABETH | COLEMAN
PREGNANCY & ADOPTION SERVICES

YOUTH MEDICAL REPORT FORM

Child's Name______________________________________ **Date of Birth**_______________

Parent's Name____

Has child had all necessary immunizations? ☐ **Yes** ☐ **No**
*If "no," please explain.*____

Is child current on TB Testing? ☐ **Yes** ☐ **No**
*Date and results of most recent TB test*____

Is child of normal development for their age? ☐ **Yes** ☐ **No**
*If "no," please explain.*____

Is child free from communicable disease? ☐ **Yes** ☐ **No**
*If "no," please explain.*____

Any special medical problems of which you are aware? ☐ **Yes** ☐ **No**
*If "yes," please explain.*____

Would you recommend an adoptive placement in this home? ☐ **Yes** ☐ **No**
*If "no," please explain.*____

Doctor's Name: ____

Address: ____

Telephone Number: ____

Doctor's Signature: ____ **Date:**____________

Please return completed form to: St. Elizabeth | Coleman Pregnancy and Adoption Services
2500 Churchman Ave
Indianapolis, IN 46203