

**AAI HEALTH STATEMENT FOR CHILD OR OTHER PERSON PRESENT IN ADOPTIVE  
FAMILY HOUSEHOLD**

Adoptive Parents: \_\_\_\_\_

Name of Child/Other Household Member: \_\_\_\_\_

**PHYSICIAN PLEASE COMPLETE THE FOLLOWING:**

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1. Please evaluate the above individual's current health status:  Healthy  Not Healthy  
(If not healthy please explain)

\_\_\_\_\_  
\_\_\_\_\_

2. Please indicate whether the individual is free from communicable disease.  Yes  No  
(If applicable include the type(s) of test(s) used and the results)

\_\_\_\_\_  
\_\_\_\_\_

3. To your knowledge, does the individual have a medical, psychological, or otherwise unfavorable health condition that would affect the adoptive child?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

4. Please indicate whether this individual is up to date with immunizations.  Yes  No  
(If not please explain)

\_\_\_\_\_  
\_\_\_\_\_

5. Additional Comments/Recommendations:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Physician, Physician designee, health dept. official)

Please print, type or stamp

Name of Physician: \_\_\_\_\_

Address of clinic: \_\_\_\_\_

Telephone/Fax: \_\_\_\_\_

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**Please mail/fax or scan this medical form to:**

**Autumn Adoptions, Inc.**

**P.O. Box 1204 Lorton, Virginia 22199-1204**

**TEL 703.646.3458 FAX 703.485.1293 EMAIL [autumnadoptions@msn.com](mailto:autumnadoptions@msn.com)**

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