



**Friday's Child Adoption Services, Inc.**  
A Virginia Licensed Child Placing Agency

**Report of Medical Examination**  
Date \_\_\_\_\_

Patients Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Any evidence of the following:			Date tests were administered (If applicable)
1. HIV	Yes	No	_____
2. Tuberculosis	Yes	No	_____
3. STD's	Yes	No	_____
4. Diabetes	Yes	No	_____
5. Hypertension	Yes	No	_____
6. Heart / Lung Disease	Yes	No	_____
7. Disease of the nervous system	Yes	No	_____
8. Malignant tumors	Yes	No	_____
9. Hepatitis / Liver Disease	Yes	No	_____
10. Psychiatric illnesses	Yes	No	_____
11. Other conditions	Yes	No	_____

I, \_\_\_\_\_ M.D. have examined  
\_\_\_\_\_ and find him/her to be in

\_\_\_\_\_ health. Based upon my examination of the patient, I find/ do not find evidence of any medical condition that would in any way impair his/her ability to adopt or to subsequently rear and care for the child.

The patient's life expectancy should be normal/reduced (circle one). I find/do not find any evidence of a history of substance abuse.

Physician Signature \_\_\_\_\_ Title \_\_\_\_\_

Physician Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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