MEDICAL APPROVAL

I have examined _____ (patient's name)
and find him/her to be in _____ health.

He/she is not known to have any communicable disease and has had a negative TB test. This patient does not have any other medical condition that would prevent him/her of parenting or raising a child. He/she should be considered as an adoptive parent based on his/her medical assessment.

Comments:
_____
_____
_____

_____ _____
Signature of the Doctor Date

_____
Printed name of doctor

_____

_____
Address of doctor

** If you have any questions about this form please feel free to contact Family to Family Adoptions, 1000 Austin Street, Suite B, Richmond, Texas 77469, 281-342-4042 **