

**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:

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\_\_\_\_\_  
Signature of the Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of doctor

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\_\_\_\_\_  
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 \*\*