| Name of applicant |  |
| --- | --- |

| Date of birth |  |
| --- | --- |

**PART A: Must be completed by the agency – write clearly in black ink/or type1**

Please describe type of caring role below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fostering |  | Tick if long term |  | Short break/respite care |  |
| Adoption |  |  |  | Intercountry adoption |  |
| Special guardianship |  |  |  | Kinship Care |  |
| Other care |  |  |  |  |  |

| **Ages and number of children applied for (if specific child, provide details)** |
| --- |
|  |

| Name of agency |  |
| --- | --- |

| Social Worker |  |
| --- | --- |

| Address |  |
| --- | --- |

| Telephone |  |
| --- | --- |
| Fax |  |
| Email |  |
| Case reference number |  |

1 This form is only to be used during the Covid 19 pandemic. A full AH process should be completed as soon as this is possible**.**

**PART B: To be completed by the applicant**

| Family name of applicant |  |
| --- | --- |
| Given name |  |
| Gender |  |

| Address |  |
| --- | --- |

| Date of birth |  |
| --- | --- |

| Occupation |  |
| --- | --- |

| Ethnic descent |  |
| --- | --- |

| GP details |  |
| --- | --- |

**2. CONSENT**

**I understand that the information about my medical history and present medical condition recorded on this form is required by the named agency and will be of great importance in decisions regarding my approval and the future placement of a child.**

**I understand that I am responsible for informing the agency if there are any subsequent significant changes in my health.**

| Signature of applicant |  |
| --- | --- |
| Date |  |

**3. Health Questions**

| Do you consider yourself to be in good health currently? | YES/NO |
| --- | --- |
| Please give details | |

| Are you seeing any specialists or hospital consultants? | YES/NO |
| --- | --- |
| If yes, please give details of who you see and where | |

| **What do you see him/her for?** |
| --- |
|  |

| Do you attend the GP for regular appointments? | YES/NO |
| --- | --- |
| If yes, what are these appointments for? | |

| Do you take any medication regularly? | YES/NO |
| --- | --- |
| If yes, please list below and clarify what each is for | |

| Have you had any health issues in the past? | YES/NO |
| --- | --- |
| If yes, please give details | |

| Have you had any emotional or mental health problems such as anxiety, depression or stress? | YES/NO |
| --- | --- |
| If yes, please give details, include any life events which may have been a trigger | |

| Do you have any significant sleep difficulties? | YES/NO |
| --- | --- |

| Have you ever seen a psychiatrist/psychologist/  psychotherapist/counsellor/psychiatric nurse/other health or social work professional or complimentary therapist for issues related to mental health? | YES/NO |
| --- | --- |
| If yes, please give details and dates | |

| Are you awaiting an appointment regarding your mental health and emotional well-being? | YES/NO |
| --- | --- |
| If yes, please provide details and dates. | |

| Have you ever attended a private health clinic or hospital? | YES/NO |
| --- | --- |
| If yes, please provide details and dates. | |

| Is your work affected by your health? Have you previously had significant time off work? | YES/NO |
| --- | --- |

| Are you on any benefits related to sickness, incapacity or disability? | YES/NO |
| --- | --- |
| If yes, please specify what and why | |

**4. Family history**

**Provide details about the health of your family. Does anyone have any serious health problems? Does anyone have any genetic conditions that may run in the family?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Age** | **State of health if living (if known)** | **Age at death and cause (if known)** |
| **Father** |  |  |  |
| **Mother** |  |  |  |
| **Brothers and sisters** |  |  |  |
| **Children** |  |  |  |
| **Other** |  |  |  |

**5. Lifestyle**

| Describe your exercise |  |
| --- | --- |
| Type |  |
| How often and how long? |  |

| Describe your diet and any dietary restrictions |  |
| --- | --- |
| Do you feel you eat a balanced diet? |  |

| Anything else important about your lifestyle |
| --- |
|  |

| Do you smoke tobacco? (cigarettes, pipe, rollups) | YES/NO |
| --- | --- |
| If yes, how long have you smoked? |  |
| How many do you smoke per day? | * 0-5 * 6-10 * 10+ |
| If no, have you ever smoked tobacco? | YES/NO |
| How many years did you smoke for? |  |
| When did you stop smoking? |  |
| Do you currently use an electronic cigarette (vaping device) | YES/NO |
| Do any other household members smoke? | YES/NO |
| Where are visitors/household members allowed to smoke in your home? |  |

| Do you drink alcohol? | YES/NO |
| --- | --- |
| What type of alcohol do you drink | * Beers/cider * Spirits * Wines |
| How much do you drink on average a week? Describe in glasses/bottles or units) |  |
| Have you ever used recreational/street/illegal drugs? | YES/NO |
| If yes, please describe use including when and type of substance | |

| What is your current weight? |  |
| --- | --- |
| What is your current height? |  |

| Please describe whether you have had any fertility treatment? |  |
| --- | --- |
| What were the dates of this treatment? |  |
| **Please describe your pregnancy history, including any pregnancy losses.** | |
|  | |

| Have you accessed any counselling in relation to the treatment? If so, please give details and say whether this continues |
| --- |
|  |

**Summary comment from agency Medical Adviser (if available)**

| **Summary of health and lifestyle issues with comments on the significance for adoption/fostering.** |
| --- |
| The comments below are based on the applicant’s self-declaration of health. |

| Signature |  |
| --- | --- |
| Date |  |
| Name |  |
| Designation |  |
| Qualifications |  |
| Address |  |
| Telephone |  |
| Fax |  |
| Email |  |