

Adoption & Attachment Treatment Center of Iowa

800 Webster Street
Iowa City, IA. 52240
Phone: 319-338-2722
Fax: 319-338-7758

Physician's Release

If family Members are under the care of separate physicians, complete a form for each member. The family should complete part C before visiting a physician.

A. To the Physician:

The individual or family named below has applied to participate in family therapy sessions, which may involve safe containment for the safety of the child and parents under the circumstances that the child may cause harm to themselves or others. It is necessary that each child and family member involved obtain this statement from their physician. Your assistance in verifying the fact that the family members are in sound health will assist us in providing therapeutic services for this family.

Patient		DOB	
Conditions being Treated:			
Patient's Street Address			
City	County	State	Zip Code

B. Physician's Statement:

? On the basis of my examination of the members of this family, each member is in sound health and there is no evidence of any medical condition or disease which would be detrimental to the well-being of the adults or children mentioned above from being involved in safe containment.

? The following problems prevent me from signing the above statement, and cause me to recommend against approval of the families participation in

List Patient's included or seen for this release: _____

Other Comments by Physician: _____

Physician's Signature

Date

C. To be completed by family, before visiting physicians:

Does any member of your immediate family have a history of any of the following?
Check yes or no. If yes, indicate each affected person's name.

<u>Yes</u>	<u>No</u>		<u>family Member(s)</u>
?	?	Epilepsy	_____
?	?	Convulsions	_____
?	?	Hepatitis	_____
?	?	Hernia	_____
?	?	Rheumatic Fever	_____
?	?	Skin Disease	_____
?	?	Diabetes	_____
?	?	Heart Disease/Problem	_____
?	?	High Blood Pressure	_____
?	?	Kidney Disease	_____
?	?	Tuberculosis	_____
?	?	Ulcers	_____
?	?	Other (specify)	_____

Has any member of your family had operations, broken bones, or serious accidents during the past two years? If so, describe below:

Type of Incident	Name of Family Member(s)	Date of Incident
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree that all findings of the examination be submitted to the Adoption & Attachment Treatment Center of Iowa. 800 Webster Street, Iowa City, IA. 52240

Signed by Parent 1	Date
Signed by Parent 2	Date