

**Please return this form to:**

Weechi-it-te-win Family Services  
P.O. Box 812, Fort Frances, ON, P9A 3N1  
Phone: (807)274-3201  
Fax: (807)274-8435



**MEDICAL STATEMENT ON FOSTER PARENT**

To the Physician:

This individual has applied to Weechi-It-Te-Win Family Services Inc. for placement of children in his/her home. We would appreciate your help in providing a written statement of the medical condition of the person named below:

{Minister's Reg s.121(2)(e)} made under the Child, Youth and Family Services Act 2017

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

D.O.B: \_\_\_\_\_

F.N. REQUESTING: \_\_\_\_\_

EXAMINATION DATE: \_\_\_\_\_

Are there any factors in this person's medical history which would physically limit his/her ability to care for children 0-18?      NO    YES

IF YES, PLEASE EXPLAIN:

In your opinion, are there any physical or emotional conditions which would make it unwise to place a child in this home?      NO    YES

IF YES, PLEASE EXPLAIN:

PHYSICIAN: \_\_\_\_\_ Signature: \_\_\_\_\_

(To be detached by the doctor for their records)

I hereby give consent to release of the above information to Weechi-It-Te-Win Family Services Inc. of the District of Rainy River.

DATE: \_\_\_\_\_ SIGNATURE \_\_\_\_\_