

Medical Evaluation for Child Care

A. Name of the Person Evaluated (please print): _____ DOB: _____

B. Name of Child Care Provider/Program: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT TO THE OFFICE OF CHILD CARE.

Signature of the person being evaluated (guardian if a minor)	Date
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This Section Must be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner

1. **DATE OF MEDICAL EVALUATION:** _____

2. **TUBERCULOSIS SCREENING:**

Risks and Symptoms screening completed (required): Yes

TB Test: if indicated or required by the Local Health Officer

Type of Test: _____ Date: _____ Results: _____

This individual is free of communicable tuberculosis. Yes No

3. **IMMUNIZATIONS:** I have discussed the importance of age-appropriate immunizations with this individual. Yes No

4. **RECOMMENDATIONS:**

The above individual is medically and emotionally fit to work, volunteer, or reside in a child care program. Yes No

If "No", please provide a summary of medical/emotional problems or conditions or medications which may affect the individual's ability to work, volunteer or reside in a child care program. _____

5. **For individuals working or volunteering in a child care program:**

The individual meets the strength and mobility challenges required for caring for a child in one or more of the age groups checked below:

0-2 years of age 2-6 years of age 7-12 years of age 12-18 years of age

6. Signature of the Health Care Provider/Designee: _____ Date: _____

Printed Name and Credentials: _____

STAMP or Complete Address and Telephone Number of the Health Care Provider: