



HOUSEHOLD MEMBERS ~DO NOT USE THIS FORM~

Caregiver Medical Statement (All Modalities)

- (CHECK ONE) Provider Substitute Volunteer
 Director Assistant Teacher
 Other Staff

INSTRUCTIONS



Submit



Maintain On-Site

- A signature is required on both pages of this form.
- Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section
- A registered nurse is **NOT** authorized to sign the Medical Condition section
- A health care provider may use an equivalent form as long as the information on this form is included

Applicant Name: _____

Date of Birth: _____

Typical Duties of Day Care Program

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Desk work
- Driver of vehicle
- Food preparation
- Facility maintenance
- Evacuation of children in an emergency

Medical Condition

Date of Exam: ____ / ____ / ____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is physically fit to provide child day care and perform the duties listed above. **YES** (symptom free) **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. **YES** (symptom free) **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. **YES** (symptom free) **NO** (NOT symptom free)

For any "No" responses, indicate Restrictions: _____

Signature (physician, physician's assistant, nurse practitioner)	
Name (Please PRINT clearly)	Title
() -	/ /
Phone	Date

(Continued on reverse)

Tear Here



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On File

- A health care provider (physician, physician's assistant, nurse practitioner) or a registered nurse (as part of their duties at a health care facility) may enter the Mantoux results in the TB section and sign this page

Applicant Name: _____

Date of Birth: _____

_____ Following to be completed by Health Professional ONLY _____

Tuberculin Test Information

Test Read on: _____
(mm / dd / yyyy)

Not Tested Reason: _____
State Medical Exemption

If applicant was previously Positive, indicate date:
_____ (mm / dd / yyyy)

Mantoux Result: Positive Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? Yes No

Signature (physician, physician's assistant, nurse practitioner OR a registered nurse)	
Name (Please PRINT clearly)	Title
() -	/ /
Phone	Date

Tear Here