



**HOUSEHOLD MEMBERS ~DO NOT USE THIS FORM~**

**Medical Statement**

(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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

(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: \_\_\_\_\_  Not Tested Reason: \_\_\_\_\_

(mm / dd / yyyy)

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