



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... A registered nurse is NOT authorized to sign the Medical Condition section...

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)

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 Director Assistant Teacher
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Maintain
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
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