

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

**MEDICAL REPORT FOR CHILD CARE**

<b>A. Name of the Person Evaluated (Please Print):</b> _____ _____	<b>D. Reason for Examination:</b> <input type="checkbox"/> Initial Employment <input type="checkbox"/> Biennial (Two Year Update) <input type="checkbox"/> Other
<b>B. Date of Birth:</b> _____ <b>Age:</b> _____	
<b>C. Name and Address of Child Care Applicant/Provider/Facility:</b> _____ _____	

<b>E. PLEASE READ: This person to be evaluated either provides or plans to provide child care services, lives in a home where child care is provided or will be provided. The Medical Evaluation is to assess this individual's ability to perform the following Child Care Activities:</b>	
<ul style="list-style-type: none"> <li>Lifting, carrying children (infants, toddlers, preschool and school age)</li> <li>Lifting/moving children furniture/equipment</li> <li>Getting up and down from floor</li> <li>Close interaction with children</li> <li>Food preparation, serving, feeding and holding young infants</li> </ul>	<ul style="list-style-type: none"> <li>Desk work, reading &amp; writing</li> <li>Active indoor and outdoor activities</li> <li>Facility maintenance</li> <li>Driver of Vehicle (s)</li> <li>Other duties associated with assisting children in need, etc.</li> </ul>

F. This Section Must Be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner			
	Yes	No	Remarks
1. Did you conduct a medical evaluation?			
a. Chronic medical conditions which may limit the ability to care for children, such as Epilepsy, asthma, others			
b. Impairment (Mobility/ Vision/ Hearing/ Speech )			
c. Nervous / Emotional/ Mental health disorder			
d. Drug /Alcohol Abuse			
e. Smoking			
f. Tuberculosis Screening: (1) symptoms check (2) screening: if needed or required by the Local Health Officer: Type of test: _____ Results: _____ Date (s): _____			
g. Communicable/Contagious diseases risk			
h. Immunization status			
2. Medical condition(s) or medication (s) the person is taking that may restrict /prevent the person's ability to perform care activities			
3. Medical limitation(s) or medication(s) the person is taking, that may require special accommodation: Please specify:			
<b>4. Based on your findings, is this individual suitable/able to provide safe care to the children in child care or live in a child care home</b>			

<b>Additional Remarks:</b>
<b>G. Signature of the Health Care Provider:</b> _____ <b>Date:</b> _____
<b>Printed Name &amp; Credentials:</b>
<b>STAMP OR Complete Address of the Health Care Provider &amp; Telephone Number:</b>