C. Medical report for persons giving care to children

MEDICAL REPORT FOR PERSONS GIVING CARE TO CHILDREN

Name:	Date of birth:
Address:	Position in child care facility:

To the examining medical doctor, physician's assistant, or certified nurse practitioner:

This examination is needed to determine my physical ability to care for children or to perform services in a child care facility (home or center) or to have contact with children in care. I hereby authorize you to furnish a report of my examination to:

_____

Name of child care facility or Department of Human Resources

_____/_____

Signature Date

TESTS (to be completed if other verification is not attached):

Date and result of Intradermal Tuberculin Test (Mantoux): _____

(Required for initial examination only)

Date and result of chest x-ray if Mantoux was positive: _____

HISTORY of any chronic disease or disability that may affect his/her ability to care for children or perform services in a child care facility: Yes ☐; No ☐.

PHYSICAL LIMITATIONS that may affect his/her ability to care for children or perform services in a child care facility (home or center): Yes ☐; No ☐.

If "YES", to either question, please explain:

_____

_____

In my opinion, the physical examination reveals that the above-named person is free of any infectious or contagious disease and is physically fit to care for children, to perform services in a child care facility, or to have contact with children.

If not, please explain:

_____

_____

_____/_____

Signature of medical doctor, physician's assistant, or certified nurse practitioner / Date