

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

MEDICAL REPORT FOR CHILD CARE

A. Name of the Person Evaluated (Please Print): _____ _____ B. Date of Birth: _____ Age: _____ C. Name and Address of Child Care Applicant/Provider/Facility: _____ _____	D. Reason for Examination: <input type="checkbox"/> Initial Employment <input type="checkbox"/> Biennial (Two Year Update) <input type="checkbox"/> Other
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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:	
<ul style="list-style-type: none"> Lifting, carrying children (infants, toddlers, preschool and school age) Lifting/moving children furniture/equipment Getting up and down from floor Close interaction with children Food preparation, serving, feeding and holding young infants 	<ul style="list-style-type: none"> Desk work, reading & writing Active indoor and outdoor activities Facility maintenance Driver of Vehicle (s) Other duties associated with assisting children in need, etc.

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:			
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			

Additional Remarks:
G. Signature of the Health Care Provider: _____
Date: _____
Printed Name & Credentials:
STAMP OR Complete Address of the Health Care Provider & Telephone Number: