MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

# MEDICAL REPORT FOR CHILD CARE

| | |
|---|---|
| A. **Name of the Person Evaluated (Please Print):** | D. Reason for Examination: |
| B. **Date of Birth:** **Age**: | ☐ Initial Employment |
| C. **Name and Address of Child Care Applicant/Provider/Facility:** Rockville Presbyterian Cooperative Nursery School (RPCNS) 215 W. Montgomery Avenue Rockville, MD 20850 | ☐ Biennial (Two Year Update) ☐ Other |

**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:***

- 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
- 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:<br>(1) symptoms check<br>(2) screening: if needed or required by the Local Health Officer:<br>Type of test:_____ Results:_____<br>Date (s):_____ | | | Not required for RPCNS |
| 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:**