MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

MEDICAL REPORT FOR CHILD CARE

Name of Person being evaluated: _____ Date of Birth: _____

Name of Child Care Applicant/Provider/Facility: _____

Address of Facility: _____

Dear Health Practitioner:

The person to be evaluated either provides (or plans to provide) child care services or lives in a home where family child care is (or will be) given.

1) **RESTRICTED OR REQUIRE SPECIAL CONDITIONS** from contact with children in care due to having any of the following:

a) Communicable disease: _____

b) Chronic medical condition or physical impairment: _____

c) Vision/Hearing/Speech Disorder: _____

d) Nervous or Emotional Disorder: _____

e) Drug or Alcohol Abuse: _____

f) Immunization status: _____

2) Tuberculosis Screening: (if needed or required by the Local Health Officer.)

Type of test: _____ Results: _____ Date: _____

Answer question 3 if the person being evaluated provides (or plans to provide) child care services:

Persons who provide child care services must be able to participate fully in a program for active young children. This includes lifting infants and young children, getting up and down from the floor, lively outdoor activities, and moving furniture. It may also include transporting children in a motor vehicle.

3) Describe medical limitation(s) or medication(s) the person is taking, that may impair the person's ability to perform care-related activities, such as the ones noted above.

_____

_____

_____

_____ _____ _____

Signature of Physician, CNP, RPA **Date** **Phone Number**

STAMP, PRINT, OR TYPE: Name and Address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

OCC 1204 - Revised 6/08 - All previous editions obsolete and replaces OCC 1258.