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/Facilit	y:	
Address of Facility:		
Dear Health Practitioner:		
The person to be evaluated either provides (or plantly child care is (or will be) given.	plans to provide) chil	ld care services or lives in a home where
1) RESTRICTED OR REQUIRE SPECIA of the following:	AL CONDITIONS f	From contact with children in care due to having
a) Communicable disease:		
b) Chronic medical condition or physi	cal 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 require	red by the Local Heal	lth Officer.)
Type of test: R	Results:	Date:
Answer question 3 if the person being evalu	ated provides (or pl	lans to provide) child care services:
Persons who provide child care services must be This includes lifting infants and young children and moving furniture. It may also include trans	n, getting up and dow	on from the floor, lively outdoor activities,
3) Describe medical limitation(s) or medicatio care-related activities, such as the ones noted al		ing, that may impair the person's ability to pe
Signature of Physician, CNP, RPA	Date	Phone Number