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:** ☐ Initial Employment ☐ Biennial (Two Year Update) ☐ Other

E. This person to be evaluated either provides/plans to provide child care services or 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, young children)	• Desk work, reading & writing
• Lifting/moving children furniture/equipment	• Active indoor and outdoor activities
• Getting up and down from floor	• Facility maintenance
• Close interaction with children	• Driver of Vehicle (s)
• Food preparation, serving, feeding and holding young infants	• Others: please list

F. This Section Must Be Completed by a Physician or Registered Physician's Assistant or Certified Registered Nurse Practitioner

	Yes	No	Remarks
1.Did you conduct a medical evaluation?			
a. Chronic medical conditions(Diabetes, Heart Disease, Hypertension, 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 to provide safe care to the children in child care or to 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: