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:** _____	☐ Biennial (Two Year Update)
St. Raphael Nursery School	☐ Other
1513 Dunster Road Rockville, MD 20854	

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: (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: