## MARYLAND STATE DEPARTMENT OF EDUCATION Office of Child Care

## **Medical Evaluation for Child Care**

A.	Name of the Person Evaluated (please print): DOB:
B.	Name of Child Care Provider:
	AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
	I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT TO THE OFFICE OF CHILD CARE.
	Signature of person being evaluated (guardian if a minor) Date
1.	This Section Must be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner
1.	DATE OF MEDICAL EVALUATION:
2.	TUBERCULOSIS SCREENING:
	Risks and Symptoms screening completed (required): $\Box$ Yes
	TB Test: if indicated or required by the Local Health Officer
	Type of Test:         Date:         Results:
	This individual is free of communicable tuberculosis. $\Box$ Yes $\Box$ No
3.	IMMUNIZATIONS: I have discussed the importance of age-appropriate immunizations with this individual. $\Box$ Yes $\Box$ No
4.	FINDINGS: Summary of medical or emotional problems or conditions or medications, if any, which may affect the individual's ability to work, volunteer or reside in a child care facility.
5.	RECOMMENDATIONS: The above individual is medically and emotionally fit to work, volunteer, or reside in a child care facility.  Yes No Explain "No":
	For individuals <b>working or volunteering</b> in a child care facility: The individual meets the strength and mobility challenges required for caring for a child in one or more of the age
	groups checked below:
	0-2 years of age 2-6 years of age 7-12 years of age 12-18 years of age
6.	Signature of the Health Care Provider/Designee:
F	Printed Name and Credentials:
S	STAMP or Complete Address and Telephone Number of the Health Care Provider: