

CONNECTICUT OFFICE OF EARLY CHILDHOOD

DIVISION OF LICENSING

ADULT MEDICAL STATEMENT for CHILD CARE

Please check one of the following boxes:

- Family Child Care Home Applicant
- Family Child Care Home Staff Assistant Applicant
- Family Child Care Home Staff Substitute Applicant
- Family Child Care Home Provider - License # _____ Expiration Date _____
- Family Child Care Home Staff Assistant – Approval # _____ Expiration Date _____
- Family child Care Home Staff Substitute – Approval # _____ Expiration Date _____
- Group Child Care Home Employee / Child Care Center Employee
- Adult Member of Household

Patient's Name _____ Phone # _____ Date of Birth ____/____/____
Street Address _____ Town _____ Zip Code _____

This section must be completed by a Physician, Physician Assistant or Advanced Practice Registered Nurse:

This medical clearance is an important requirement in child care licensing laws designed to protect the health, safety and welfare of the children in day care.

1. To the best of your knowledge, does this person have any medical or emotional illness or disorder that would currently pose a risk to children in their care or would interfere with or jeopardize a caregiver's ability to render proper care for children in the child care facility? YES NO

If yes, please explain: _____

2. Date of patient's MOST RECENT examination: _____

3. Required check for Tuberculosis: Tuberculin skin test Date _____ Positive Negative
(upon employment or initial application) or Chest x-ray Date _____ Positive Negative

4. Medical Provider's Information Name: _____
Address: _____
Phone #: _____

5. _____ / _____
Signature of MD, APRN or PA Date