

# Parent Health Form

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/Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Dear Health Practitioner:

The person to be evaluated either provides (or plans to provide) child care services or lives in a home where family child care is (or will be) given.

1) **RESTRICTED OR REQUIRE SPECIAL CONDITIONS** from contact with children in care due to having any of the following:

a) Communicable disease: \_\_\_\_\_

b) Chronic medical condition or physical 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 required by the Local Health Officer.)

Type of test: \_\_\_\_\_ Results: \_\_\_\_\_ Date: \_\_\_\_\_

**Answer question 3 if the person being evaluated provides (or plans to provide) child care services:**

Persons who provide child care services must be able to participate fully in a program for active young children. This includes lifting infants and young children, getting up and down from the floor, lively outdoor activities, and moving furniture. It may also include transporting children in a motor vehicle.

3) Describe medical limitation(s) or medication(s) the person is taking, that may impair the person's ability to perform care-related activities, such as the ones noted above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician, CNP, RPA**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Phone Number**

**STAMP, PRINT, OR TYPE: Name and Address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.**