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/Program: ____

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 the person being evaluated (guardian if a minor)	Date

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): ☐ Yes
   TB Test: if indicated or required by the Local Health Officer
   Type of Test: ____________________ Date: __________ Results: ____________________
   This individual is free of communicable tuberculosis. ☐ Yes ☐ No

3. IMMUNIZATIONS: I have discussed the importance of age-appropriate immunizations with this individual. ☐ Yes ☐ No

4. RECOMMENDATIONS:
   The above individual is medically and emotionally fit to work, volunteer, or reside in a child care program. ☐ Yes ☐ No

   If "No", please provide a summary of medical/emotional problems or conditions or medications which may affect the individual's ability to work, volunteer or reside in a child care program. ______________________________

   ____

5. <u>For individuals **working or volunteering** in a child care program:</u>

   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: ___________________________ Date: ______________

Printed Name and Credentials: ____

STAMP or Complete Address and Telephone Number of the Health Care Provider: