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): ☐ 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. 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 **working or volunteering** 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: _____Date: _____

Printed Name and Credentials: _____
STAMP or Complete Address and Telephone Number of the Health Care Provider: