MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

Medical Evaluation for Child Care

A. Name of the Person Evaluated (please print):_____

B. Date of Birth:_____ Age:_____

C. Name and Address of Child Care Applicant/Provider/Facility:_____

_____

D. Date of Evaluation:_____

E. **PLEASE READ**: **This person to be evaluated either provides or plans to provide child care services, or lives in a home where child care is provided or will be provided. The Medical Evaluation is to assess this individual's ability to perform the following Child Care Activities:**

- Lifting, carrying children (infants, toddlers, preschool and school age)
- Lifting/moving children, furniture/equipment
- Getting up and down from floor
- Close interaction with children
- Food preparation, serving, feeding and holding young infants
- Deskwork, reading & writing
- Active indoor and outdoor activities
- Facility maintenance
- Driver of Vehicle (s)
- Other duties associated with assisting children in need, etc.

F. This Section Must be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner

	Yes	No	Remarks
1. Did you conduct a medical evaluation?			
a. Chronic medical conditions that may limit the ability to care for children			
b. Impairment (Mobility/ Vision/ Hearing/ Speech)			
c. Nervous/ Emotional/ Mental health disorder			
d. Drug/Alcohol Abuse			
e. Smoking			
f. Tuberculosis Screening: (1) Symptoms Check (2) Screening test: if needed or required by the Local Health Officer: Type of test:_____ Results: _____ Date(s):_____			
g. Communicable/Contagious disease risk			
h. Immunization Status			
2. Medical conditions(s) or medication(s) the person is taking that may restrict/prevent the person's ability to perform care activities			
3. Medical limitations or medication(s) the person is taking, that may require special accommodation: Please specify:			
4. Based on your findings, is this individual suitable/able to provide safe care to the children in child care or live in a childcare home?			

Additional Remarks:_____

5. Signature of the Health Care Provider/Designee:_____

Printed Name and Credentials:_____

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