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: (upon employment or initial application for Child Care Center and Group Child Care Home staff ONLY)
   Tuberculin skin test Date _____ ☐ Positive ☐ Negative
   or Chest x-ray Date _____ ☐ Positive ☐ Negative

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

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

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