LDSS-4434-1 (Rev. 9/2009) Reverse

**HOUSEHOLD MEMBERS ~DO NOT USE THIS FORM~**

# Medical Statement

(CHECK ONE) ☐ Provider ☐ Substitute ☐ Volunteer ☐ Director ☐ Assistant ☐ Teacher ☐ Other Staff

**INSTRUCTIONS**

Submit

Maintain On File

- *A health care provider (physician, physician's assistant, nurse practitioner) or a registered nurse (as part of their duties at a health care facility) may enter the Mantoux results in the TB section and sign this page*

| Applicant Name: | Date of Birth: |
|---|---|
| | |

**Following to be completed by Health Professional ONLY**

## Tuberculin Test Information

Test Read on: _____ (mm / dd / yyyy)

☐ Not Tested Reason: _____ State Medical Exemption

If applicant was previously Positive, indicate date: _____ (mm / dd / yyyy)

**Mantoux Result:** ☐ Positive ☐ Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? ☐ Yes ☐ No

| | |
|---|---|
| **Signature** *(physician, physician's assistant, nurse practitioner OR a registered nurse)* | |
| **Name** *(Please PRINT clearly)* | **Title** |
| ( ) - | / / **Date** |
| **Phone** | |

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LDSS-4434-1 (Rev 9/2009) Front

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# Medical Statement

(CHECK ONE) ☐ Provider ☐ Substitute ☐ Volunteer ☐ Director ☐ Assistant ☐ Teacher ☐ Other Staff

**INSTRUCTIONS**

Submit

Maintain On-Site

- *A signature is required on both pages of this form.*
- *Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section*
- ***A registered nurse is NOT authorized to sign the Medical Condition section***
- *A health care provider may use an equivalent form as long as the information on this form is included*

| Applicant Name: | Date of Birth: |
|---|---|
| | |

## Typical Duties of Day Care Program

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Desk work
- Driver of vehicle
- Food preparation
- Facility maintenance
- Evacuation of children in an emergency

## Medical Condition

Date of Exam: _____/_____/_____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is physically fit to provide child day care and perform the duties listed above. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*
- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*

**For any "No" responses,** indicate Restrictions: _____

_____

_____

_____

| **Signature** *(physician, physician's assistant, nurse practitioner)* | |
|---|---|
| **Name** *(Please PRINT clearly)* | **Title** |
| ( ) - | / / |
| **Phone** | **Date** |

*(Continued on reverse)*

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