Tennessee Department of Human Services

Child Care Provider Medical Report

A.TO BE COMPLETED BY PROVIDER:

Name:_____ DOB:_____

Address:_____

Street City State Zip Code

I, _____, hereby authorize the physician(s) name below to release information to the Tennessee Department of Human Services for approval/licensure or employment as a child care provider.

Name of Physician(s):	Address:

Purpose of examination:	**Type of Activity in Child Care (check all that apply):**
☐ Initial Employment	☐ Caregiver ☐ Food Preparation ☐ Driver ☐ Facility Maintenance
☐ Re-examination	☐ Other:_____

B.TO BE COMPLETED BY PHYSICIAN(S):

1. How long have you known this patient or have had knowledge of their medical history? _____

2. In your opinion, does this person have:

	YES	NO
a. The agility to move quickly to keep pace with toddlers?	☐	☐
b. The stamina to remain alert and energetic for 8 hours or more?	☐	☐
c. Any condition which requires restriction of activity or which could affect patient's temperament and interaction with children? (If so, explain in Number 3)	☐	☐

3. Specify any physical, mental, or emotional limitation affecting this person's ability to care for a group of children.

_____

_____

4. Is this patient currently taking any medications which could affect their work role or interaction with children?
   ☐ Yes ☐No If yes, please explain:_____

5. This patient has been screened and/or tested for all communicable diseases as required by the Department of Health. ☐ Yes ☐ No

6. Additional Comments:_____

_____ _____

Medical Professional Signature Date