CONNECTICUT OFFICE OF EARLY CHILDHOOD

DIVISION OF LICENSING

ADULT MEDICAL STATEMENT for CHILD DAY CARE

Please check one of the following boxes:

☐ Family Day Care Home Applicant

☐ Family Day Care Home Staff Assistant Applicant

☐ Family Day Care Home Staff Substitute Applicant

☐ Family Day Care Home Provider - License # _____________ Expiration Date ________

☐ Family Day Care Home Staff Assistant – Approval # ________ Expiration Date ________

☐ Family Day Care Home Staff Substitute – Approval # ________ Expiration Date ________

☐ Group Day Care Home Employee / Child Day 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 day 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 day care facility? ☐ YES ☐ NO
   If yes, please explain: ____
   ____

2. Date of patient's MOST RECENT examination: ______________________

3. Required check for Tuberculosis: Tuberculin skin test Date _________________ ☐ Positive ☐ Negative
   (upon employment or initial application) 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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