

PART II – MEDICAL EVALUATION

To be completed by a Health Practitioner

Child's Name: _____

1. Date of this child's most recent tuberculin test: ____/____/____ Results: ____ POSITIVE ____ NEGATIVE

2. This child has the following, which may significantly affect his/her childcare or educational experience:

				COMMENTS
a. Vision problem	___ Yes ___ No			_____
b. Hearing problem	___ Yes ___ No			_____
c. Speech or language problem	___ Yes ___ No			_____
d. Other physical illness or impairment	___ Yes ___ No			_____
e. Mental, emotional or behavior problems	___ Yes ___ No			_____
f. Developmental delays	___ Yes ___ No			_____
g. Allergies	___ Yes ___ No			_____

Significant physical findings, comments, and recommendations: _____

3. This child has a health condition, which may require care or emergency action while at childcare/school. ____ Yes ____ No

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

4. This child has or is a known carrier of a communicable disease, which should prevent his/her admission to a childcare facility or school. ____ Yes ____ No

If yes, please specify: _____

5. This child requires a modified diet and/or special feeding procedures. ____ Yes ____ No

If yes, please specify: _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

6. If child cannot fully participate in all areas of daycare program, what areas should be limited or altered to suit his/her needs?

7. Does child's physical activity need to be restricted? ____ Yes ____ No

If yes, please specify: _____

8. Does this child require any specialized treatment? ____ Yes ____ No

If yes, please specify: _____

9. Does this child require any adaptive equipment (braces, crutches, etc.)? ____ Yes ____ No

If yes, please specify type: _____

Special instructions for use: _____

10. Additional comments: _____

HEALTH PRACTITIONER'S STATEMENT

I conducted a physical examination of the above-named child on _____ and find that he/she ____ IS ____ IS NOT
medically cleared to attend childcare or school. (Date) (Check One)

Name of Health Practitioner (Please Print)

Telephone Number

Date

Signature of Health Practitioner