

**MEDICAL REPORT ON AN ADULT IN A CHILD CARE FACILITY**

(Includes employees and volunteers in DCFS licensed child care facilities, operators of day care/group day care homes and other adult members of their households)

\_\_\_\_\_  
(Name of Person Examined) (Birth Date)

Position (check one)

- Day Care/Group Day Care Home Caregiver
- Child Care Staff
- Other Staff in a Child Care Facility
- Member of Household
- Food Handler (See Section B)
- Child Care Facility Driver (See Section B)
- Volunteer in a Child Care Facility

Name of Licensee/applicant for License or Licensed Facility where individual is employed/volunteers \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip Code County

I. TESTS	Date	Results
Tuberculin test (by the Mantoux method or chest X-ray in a positive reactor)*	_____	_____
Other (specify): _____	_____	_____

II. FINDINGS AND RECOMMENDATIONS

A. Findings

Summary of medical or emotional problems or conditions, if any, which may affect the individual's ability to work, volunteer or reside in a facility caring for children.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Any conditions which contraindicate a person serving as a Food Handler or Child Care Facility Driver?

Yes  No

If yes, please specify \_\_\_\_\_

C. Recommendations

The above individual was found free from symptoms of communicable disease and is otherwise medically and emotionally fit to work, volunteer or reside in a facility caring for children.  Yes  No

Explain "No": \_\_\_\_\_

In my opinion, the individual could meet the strength and mobility challenges required for caring for a child in one or more of the age groups checked below:

- 0-2 years of age
- 2-6 years of age
- 7-12 years of age
- 12-18 years of age

\_\_\_\_\_  
Date of Examination Physician's Name (Print) and State License Number

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Telephone Number

\* Required in initial examination only. Physician to determine need for test in subsequent examinations.

# REEXAMINATIONS

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Date of Examination

Physician's Name (Print) and State License Number

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