PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ____/ ____/ ____ Result: _____Positive _____Negative

2. This child has the following which may significantly affect his/her child care 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 child care/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 child care 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 this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

_____

7. Does this 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 child care or school.
(circle correct response)

_____ ( ) _____
Name of Health Practitioner *(Please Print)* Telephone Number

_____ _____
Signature of Health Practitioner Date