STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

ADULT MEDICAL STATEMENT for CHILD DAY CARE

☐ **Group Day Care Homes** ☐ **Child Day Care Centers: MAINTAIN ON FILE-DO NOT RETURN to the Dept. of Public Health**

Day Care Facility Name _____ License # _____

Day Care Location Address _____Town _____Zip Code _____

****

☐ **Family Day Care Home** ☐ **Family Day Care Staff** **Mail to:** Department of Public Health, Day Care Licensing Program, 410 Capitol Avenue, MS#12 DAC, P. O. Box 340308, Hartford, CT 06134-0308. Telephone 1800-282-6063, 1-800-439-0437 or (860) 509-8045

Applicant/Provider Name _____ License # _____

Provider's Location Address _____Town _____ Zip Code _____

☐ New Application ☐ Renewal Application ☐ Staff Application

Your patient plans to care for and supervise a group of young children for several hours at a time. 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.

Patient's Name _____ Date of Birth ____/____/____

Address _____

Town _____ Zip Code _____Phone (____)_____

Position in Day Care Facility

☐ Main caregiver for children
☐ Staff or Substitute
☐ Adult member of household
☐ Other _____

To be completed by a Physician, Physician Assistant, or Advanced Practice Registered Nurse:

1. To the best of your knowledge, is the person taking any medication that may negatively affect the care, supervision, health, safety or welfare of day care children? ☐ YES ☐ NO If yes, explain: _____

_____

_____

2. 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 day care or would interfere with or jeopardize a caregiver's ability to render proper care for children?
☐ YES ☐ NO If yes, explain: _____

_____

_____

3. Date of patient's **MOST RECENT** EXAMINATION _____

4. Required Check for Tuberculosis: (At time of initial employment only) Tuberculin skin test or Chest x-ray
Date _____ ☐ Positive ☐ Negative
Date _____ ☐ Positive ☐ Negative

Medical Care Provider (Name, Address, Telephone #)

_____
Signature of MD, APRN or PA

Date Form Signed _____

Phone: (860) 509-8045, Fax: (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer