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: (upon employment or initial application)
   Tuberculin skin test Date _____ ☐ Positive ☐ Negative
   or Chest x-ray Date _____ ☐ Positive ☐ Negative

4. Medical Provider's Information
   Name: _____
   Address: _____
   Phone #: _____

5. _____ / _____
   Signature of MD, APRN or PA Date

Connecticut Office of Early Childhood
410 Capitol Avenue – MS #12 CBR
P.O. Box 340308
Hartford, CT 06134-0308 Phone# 1-800-282-6063 or (860)509-8045 Fax#860-509-7541

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date:_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

_____ May participate in all camp activities

_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies:_____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):_____

Does the individual have allergies? ☐ YES ☐ NO Explain**:** _____

Is the individual on a special diet? ☐ YES ☐ NO Explain**:** _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number