CONNECTICUT OFFICE OF EARLY CHILDHOOD

DIVISION OF LICENSING

ADULT MEDICAL STATEMENT for CHILD CARE

Please check one of the following boxes:

☐ Family Child Care Home Applicant

☐ Family Child Care Home Staff Assistant Applicant

☐ Family Child Care Home Staff Substitute Applicant

☐ Family Child Care Home Provider - License # _____ Expiration Date _____

☐ Family Child Care Home Staff Assistant – Approval # _____ Expiration Date _____

☐ Family child Care Home Staff Substitute – Approval # _____ Expiration Date _____

☐ Adult Member of Household

☐ Group Child Care Home Employee / Child Care Center Employee

****Please provide this form to the patient, do not send directly to the Office of Early Childhood***

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 child 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 child care facility? ☐ YES ☐ NO

   If yes, please explain:

   _____

   _____

2. Date of patient's MOST RECENT examination: _____

3. Medical Provider's Information Name: _____

   Address: _____

   Phone #: _____

4. _____ / _____

   Signature of MD, APRN or PA Date