West Virginia Department of Health and Human Resources

Statement of Good Health for Informal, Relative and In-Home Providers

Provider Name __________________________________________

Date of Birth ____________

(Last) (First) (Middle)

MEDICATIONS:

Is the patient on any medication that might impact the ability to care for children? If so, please describe below:

______________________________________________________________________________
______________________________________________________________________________

PHYSICAL/MENTAL HEALTH

Is the examiner the regular family physician for the patient? ☐ Yes ☐ No

Is the examiner aware of any physical condition(s) that might prevent the patient from performing tasks typically required of the child care provider, such as: moving quickly to supervise young children: lifting children, equipment or supplies: hearing and seeing at a distance for playground supervision or driving? ☐Yes ☐ No If so, please describe below:

______________________________________________________________________________
______________________________________________________________________________

Is the examiner aware of any mental health condition (s) that might impact the patient=s ability to provide a safe and emotionally healthy environment for young children? ☐Yes ☐ No If so, please describe below:

______________________________________________________________________________

Is the examiner aware of any medical condition present in the patient which poses a public health risk? ☐Yes ☐ No. If so, please describe:

______________________________________________________________________________

Signature ____________________________ MD/DO/PA/CRNP

Exam Date ____________________________

ECE-CC-3B
(04/2014)