

West Virginia Department of Health and Human Resources
CHILD CARE PROVIDER MEDICAL REPORT

Name of Provider: _____ **Date of Birth:** _____
(Last) (First) (Middle)

Examiner Name and Address: (please print) _____

MEDICAL HISTORY

Illnesses _____

Mental Health Issues _____

Operations _____

Hospitalizations _____

Accidents _____

STATEMENT CONCERNING PRESENT PHYSICAL CONDITION AND GENERAL HEALTH

Lungs _____ Heart _____

Pulse _____ Blood Pressure _____ Weight _____ Height _____

Is any recommendation for medical care being made to this patient? If so, please describe: _____

LABORATORY TESTS

Mantoux (PPD) or Chest X-ray (required every two years): Date _____ Result _____

Vision and Hearing _____

Other Laboratory Tests _____

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 child care providers, 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:** _____

(Indicate one)