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 patients 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)