STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
CHILD CARE PROVIDER MEDICAL REPORT

A. TO BE COMPLETED BY PROVIDER:

Name: _____ Birth Date: _____

Address: _____
Street City State Zip Code

I, _____, hereby authorize the physician(s) name below to release information
(Provider/Patient's Signature)
to the Department of Human Services for approval/licensure or employment as a child care provider.

Name of Physician(s):	Address:

Purpose of Examination:	**Type of Activity In Child Care (check all that apply):**
☐ Initial Employment	☐ Caregiver ☐ Food Preparation ☐ Driver ☐ Facility Maintenance
☐ Re-examination	☐ Other: _____

B. TO BE COMPLETED BY PHYSICIAN(S):

1. How long have you known this patient or have had knowledge of their medical history? _____

2. In your opinion, does this person have:

	YES	NO
a. The ability to lift 40 pounds?	_____	_____
b. The agility to move quickly to keep pace with toddlers?	_____	_____
c. The stamina to remain alert and energetic for 8 hours or more?	_____	_____
d. Any condition which requires restriction of activity or which could affect patient's temperament and interaction with children? (If so, explain in Number 3)	_____	_____

3. Specify any physical, mental, or emotional limitation affecting this person's ability to care for a group of children.
_____
_____

4. Is this patient currently taking any medications which could affect their work role or interaction with children?
☐ Yes ☐ No If yes, please explain: _____
_____

5. Additional Comments: _____
_____
_____

_____ _____
Physician's Signature Date

_____ _____
Physician's Signature Date