Health Examination Form

Use this form at the time of an initial or change of family child care registration application when there is a new household member, substitute, assistant, or alternate. Ensure form is signed by both the patient and the doctor.

Please check one: ___provider ___alternate ___assistant ___household member ___substitute

To be completed by person checked above:

Patient's name _____Date of Birth_____,
I am a person living or working in a home being evaluated as a New Jersey State Registered Family Child Care Home. I authorize (**doctor's name**) _____ to release medical information concerning me to (**sponsoring organization**):

_____
in connection with the family day care registration application for (**name of provider**). I understand that the sponsoring organization will keep this information confidential.

Patient's signature _____ Date _____

To be completed by physician:

The above-named patient is a household member or staff in a New Jersey State registered family child care provider applicant's home and who will be present during the operation of the child care program. New Jersey State regulations require a physician's statement verifying the household member/staff person is in good health, and free from communicable disease. The children which may be enrolled in this program may include children from birth to 13 years of age. To assist us in evaluating the application, we are asking you to answer the questions below to the best of your knowledge. For further information, please contact:

_____ at (phone) _____

1. Does the patient regularly take medication? _____ (yes or no)
   If yes, what medication, diagnosis and possible side effects?

_____

_____

_____

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2. Does the patient have a current communicable disease? _____ (yes or no)

If yes, please describe: _____

_____

_____

3. How would you describe the patient's general physical and mental health? (Check A, B or C)

A. _____ Good physical and mental health

B. _____ Health problem, but no limitations to be in the presence of children.

C. _____Health problem that may affect the enrolled children in the home. Please explain:

_____

_____

_____

4. Are you aware of any reason that this household member should not be left unsupervised with enrolled children, which may include children from birth to 13 years of age. _____ _____(yes or no). If yes, please explain:_____

_____

Physician signature _____ Date _____

Telephone _____

Physician's name and office address (please print or stamp)

_____

_____

_____