

Physician Statement



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Please have this form stamped by physician, or it will be returned and cause a delay in your paperwork.

To be completed by Family Child Care provider, assistant and/or alternate, substitute or family member who is home during business hours.

Patient's name: _____

I am applying to be a registered provider provider assistant alternate
 substitute family member (please check one)

I authorize Dr.: _____ to release medical information concerning me to (sponsoring organization) **Community Coordinated Child Care of Union County** in connection with my application for my family child care registration.

Signature: _____ Date: _____

If patient is a provider assistant or alternate, give providers' name and town:

To be completed by physician:

The above named patient is applying for registration as a family day care provider or provider assistant. New Jersey State regulations require a physician's statement verifying the applicant is in good health, free from communicable disease and able to care for children. To assist us in evaluating the applicant, we are asking you to answer the questions below to the best of your knowledge. For further information, please contact: **Sandra Lee-Chow at Community Coordinated Child Care** (telephone): (973) 923-1433 ext. 137.

1. Has the patient been tested for communicable TB? (yes or no) If yes, please state: Date: _____ Test: _____ Results _____

(Note: A Mantoux test is required with 5 TU of PPD tuberculin. A tine test is not acceptable. A chest x-ray is required if the patient has had a previous positive Mantoux test.)

2. Does the patient regularly take medication? _____ Yes or _____ No. If yes, could this medication adversely affect his or her ability to care for children? _____ (yes or no) if yes, please explain why: _____

3. Does the patient have a current communicable disease? _____ (yes or no) if yes, please describe: _____

4. How would you describe the patient's general physical and mental health?

(check A, B or C)

A. _____ Good physical and mental health, no limitations for work with children.

B. _____ Health problem, but no limitations for work with children.

Please explain:

C. _____ Health problem that would limit ability to work with children.

Please explain:

Physician's signature: _____

Physician's name (please print): _____

Office address: _____

Telephone: _____ Date of examination _____