CFS 602
Rev. 03/2016

STATE OF ILLINOIS
Department of Children and Family Services

MEDICAL REPORT ON AN ADULT IN A CHILD CARE FACILITY

(Includes employees and volunteers in DCFS licensed child care facilities, operators of day care/group day care homes and other adult members of their households)

______________________________ (Name of Person Examined)　　______________ (Birth Date)

Position (check one)

- ☐ Day Care/Group Day Care Home Caregiver
- ☐ Child Care Staff
- ☐ Other Staff in a Child Care Facility
- ☐ Member of Household
- ☐ Food Handler (See Section B)
- ☐ Child Care Facility Driver (See Section B)
- ☐ Volunteer in a Child Care Facility

Name of Licensee/applicant for License or Licensed Facility where individual is employed/volunteers ______________________________

Address ______________________________
Street　　City　　Zip Code　　County

I. TESTS

		Date	Results
Tuberculin test (by the Mantoux method or chest X-ray in a positive reactor)*		________	________
Other (specify):	________	________	________
	________	________	________

II. IMMUNIZATIONS

☐ Yes ☐ No I have discussed the importance of immunizations for adult child care providers with this individual and recommend the following immunizations: ______________________________

If this individual is employed in a child care facility that cares for children age 6 and under, please check two of the following:

This individual has received: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccine **or** is immune to MMR.

This individual is not medically indicated for: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccinations.

III. FINDINGS AND RECOMMENDATIONS

A. Findings

Summary of medical or emotional problems or conditions, if any, which may affect the individual's ability to work, volunteer or reside in a facility caring for children.

____
____
____

B. Any conditions which contraindicate a person serving as a Food Handler or Child Care Facility Driver?

☐ Yes ☐ No If yes, please specify ______________________________

C. Recommendations

The above individual was found free from symptoms of communicable disease and is otherwise medically and emotionally fit to work, volunteer or reside in a facility caring for children. ☐ Yes ☐ No

Explain "No": ______________________________

In my opinion, the individual could meet the strength and mobility challenges required for caring for a child in one or more of the age groups checked below:

☐ 0-2 years of age ☐ 2-6 years of age ☐ 7-12 years of age ☐ 12-18 years of age

______________ Date of Examination

______________________________ Physician's Name (Print) and State License Number

______________________________ Physician's Signature

______________________________ Street Address　　City　　State　　Zip Code

______________________________ Telephone Number

* Required in initial examination only. Physician to determine need for test in subsequent examinations.

REEXAMINATIONS

Date of Examination | Physician's Name (Print) and State License Number

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