CFS 602
Rev. 9/2002

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. 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

Date of Examination

Physician's Name (Print) and State License Number

Date of Examination

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