Department of Early Education and Care
THE COMMONWEALTH OF MASSACHUSETTS

# Family Child Care Medical Form

Dear Physician/Health Care Professional:

The Department of Early Education and Care requires that all persons who will be caring for children in their homes or working as an assistant in a licensed family child care home be examined by a physician/health care professional. EEC allows a licensee or a certified assistant to care for up to eight children under the age of fourteen without any assistance provided two of the children are school age.

Your patient, _____, is required to submit this medical form as part of his/her licensing or certification requirement. Please fill out the form in its entirety and return it to your patient.

Name of patient: _____Date of birth: _____

Address: _____

_____

Date of Examination:_____

In your professional opinion what is the status of your patient's general physical and mental health?

_____

_____

_____

_____

In your professional opinion does your patient have any limitations (for example side effects of medication, inability to lift, etc.) that would affect his/her ability to work with young children? If yes, please provide details of any of these limitations.

_____

_____

_____

Are you the patient's treating physician/health care professional? _____ If so, how long have you been treating this patient? _____

If not, how many times have you seen this patient? _____

Comments: _____

Has this person been immunized in accordance with the requirements of the Department of Public Health (Mumps, Measles and Rubella)?

_____ Yes _____ No

Family child care educators may be granted a medical exemption if they are able to provide documentation signed by a physician stating the specific medical exemption. Please indicate whether your patient should be medically exempted from proving immunity to these diseases based on the fact that re-vaccination may be medically contraindicated.

_____

_____

_____

_____ _____

Signature of Physician/Health Care Professional

Please print your name, address, telephone number, and license number

_____ _____

Date

_____

_____

_____