

STATE OF HAWAII – DEPARTMENT OF HUMAN SERVICES

MEDICAL REPORT

(Confidential)

Part I. For the Applicant/Employee/Household Member to complete:

Name: _____	Date of Birth: _____
Address: _____	Contact Number: _____

Name of Child Care Facility: _____	
Check and List Your Position in the Child Care Facility: (Applicant, Household member, Employee (list name of position), Substitute, Volunteer, etc.)	<input type="checkbox"/> Group Child Care Home
<input type="checkbox"/> Family Child Care Home	<input type="checkbox"/> Infant & Toddler Child Care Center
<input type="checkbox"/> Group Child Care Center	<input type="checkbox"/> Before & After School Child Care Facility

To the examining physician (MD), physician assistant (PA), advanced practice registered nurse (APRN), nurse practitioner (NP):

This examination is needed to help the Department evaluate my ability to care for children in a licensed child care facility or to have contact with the children. I hereby authorize you to furnish a report of my medical report to the Department of Human Services and/or to the child care facility.

Please complete every item, or indicate “not applicable” where appropriate. When completed, please sign, date, and return the form to me or the name and address listed below.

Signature Date

Return Medical Report to: _____

Part II. For the MD, PA, APRN, NP to complete:

TESTS (to be completed if other verification of Tuberculin Test result is not attached):

Date and result of Tuberculin Test (Mantoux): _____

Date and result of chest x-ray if Mantoux was positive: _____

HISTORY of any physical disability or mental health disorder that may affect the above-named person's ability to perform the duties or cope with the responsibilities of providing care for children:

Yes; No. If "Yes", please explain:

LIMITATIONS, physical or mental, that may affect the above-named person's ability to perform the duties or cope with the responsibilities of providing care for children:

Yes; No. If "Yes", please explain:

In my opinion, the physical examination reveals that the above-named person is free of any communicable disease and is physically and mentally fit to perform the duties of providing care for children or to have contact with the children as a household member:

Yes; No. If "No", please explain:

Examined by: _____

Signature

Date

Contact Number

Print name of physician, physician assistant, advanced practice registered nurse, nurse practitioner

Address
