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

Date of Examination

Physician's Name (Print) and State License Number

Date of Examination

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