CFS 602
Rev. 03/2015

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: _______________________________

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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