DAKOTA COUNTY FAMILY CHILD CARE PHYSICIAN'S REPORT

Section I – To Be Completed By The Subject (Patient)

Applicant / Licensed Provider Name:		
Patient Name:	**Patient Date of Birth:**	
Patient Address:		
Patient Relationship to Provider:	❑ Primary License Holder	❑ Adult Assistant or Substitute Caregiver

Authorization for Release of Medical Information:

I authorize my physician / clinic to release any and all medical information pertinent to my suitability as a provider licensed to care for children ages 6 weeks to 11 years in my home to: Dakota County Family Child Care Licensing. I understand that refusal to release information may affect the ability of Dakota County to complete my application. I understand that my records are protected under the Minnesota Government Data Practices Act (Minn. Stat. Chapter 13), the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162, and 164), and other applicable State and Federal privacy laws. I understand that my medical information cannot be released without my written consent, unless otherwise authorized by law, and that I am under NO OBLIGATION to release it. I understand that I may release all, some or none of the information. I understand that I have the right to see the information and have a copy of it. I may revoke this Authorization at any time in writing however, revocation will not pertain to data released or obtained prior to the County's receipt of the written revocation notice at Dakota County Social Services, 14955 Galaxie Ave., Apple Valley, MN 55124. Unless I revoke my consent sooner, my permission to allow the release of this information will automatically expire one (1) year from the date I sign this release. I understand that in accordance with 45 CFR § 164.508 (c) (2)(iii), Dakota County is informing me that the individual(s) or entities whom you are authorizing Dakota County to disclose my information to may not be subject to the same privacy rules as Dakota County and there may be the potential of re-disclosure of the private information.

____ _______________________________
Signature of Subject Date

This Individual is Applying to:

- ❑ Become a Licensed Caregiver
- ❑ Work As a Second Adult With a Licensed Caregiver
- ❑ Be a Substitute Caregiver (less than 30 days in any 12-month period)

Section II -- To Be Completed By The Examining Physician:

<u>Family child care is a physically and mentally demanding, largely unsupervised occupation.</u> This applicant may be providing care for up to 12-14 children. In the interest of children served in child care homes, please provide the following information:

Date of Most Recent Physical Exam: ___/___/___	Date of Most Recent Office Visit: ___/___/___	How Long Has This Patient Been Under Your Care:

Is there another physician / medical professional / other professional we should consult prior to making a decision about this individual being a caregiver?

❑ Yes ______________________________ ❑ No
Name of Professional

To your knowledge, does this individual have a current physical or mental health condition or treatment protocol that could present problems in the performance of their child care responsibilities?

- ❑ Yes (Please describe)____
- ❑ No

Are the immunizations current on this individual? If not, please specify any vaccinations needed:

- ❑ Yes
- ❑ No ____

Is this patient / should this patient be taking any medications on a regular basis? If so, please specify the medical condition and prescribed medication. Will the treatment, condition or side effect have any negative effect on the patient's ability to provide care during daytime, evening or overnight hours?

Medical Condition	Medication//Treatment	Side effects which may affect the patient's ability to care for children	Is this a Communicable Disease?	
			❑ Yes	❑ No
			❑ Yes	❑ No
			❑ Yes	❑ No
			❑ Yes	❑ No

Specify any physical limitation(s) of this individual's ability to perform the following work activities:

Work Activity	**Permanent Limitation?**		**If Temporary, Duration**
Sitting	❑ Yes	❑ No	
Standing	❑ Yes	❑ No	
Walking	❑ Yes	❑ No	
Lifting	❑ Yes	❑ No	
Carrying	❑ Yes	❑ No	
Handling Objects	❑ Yes	❑ No	
Hearing	❑ Yes	❑ No	
Speaking	❑ Yes	❑ No	
Traveling	❑ Yes	❑ No	

Is this condition: ❑ Acute ❑ Chronic

When should this individual be reassessed: ____

Capability of Caring for Children:

In your professional opinion, is this individual capable of providing full-time (40 hours or more per week), in-home family childcare services for children, ages 6 weeks to 11 years:

❑ Yes ❑ No

Comments: ____

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Name of Examining Physician (please print)	Signature of Examining Physician	Date
Physician / Clinic Address	City / State / Zip Code	Telephone

Name of Person Completing This Form (If Other Than Physician)	Title