

MEDICAL CLEARANCE REQUEST

PATIENT INFORMATION: (To be completed by patient)			
Name (Last, First, Middle, Jr., II, etc.)	Birth Date	Social Security #	
Address (Street Number and Name)	City	State and Zip	
RELEASE OF INFORMATION: (To be completed by patient)			
"I hereby authorize the physician named to release medical information concerning me to _____ for the purpose of determining my suitability to provide or be associated with care of children. This release expires 180 days from the date signed by me."			
Patient's Signature	Date	Physician's Name/Please PRINT or TYPE	
MEDICAL INFORMATION: (To be complete by Physician)			
It is necessary to establish that those providing direct care are in such physical and mental health as will not adversely affect the health or safety of a child and the quality and manner of his or her care. To assist us in this determination, we are asking that you answer the questions below:			
Has this Person been tested for T.B. <input type="checkbox"/> NO <input type="checkbox"/> YES, if yes ->	Date Tested	Test Type <input type="checkbox"/> Skin Test <input type="checkbox"/> X-ray	Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative (explain in comments)
How would you describe this patient's general physical/mental health? <input type="checkbox"/> Good physical and mental health, no limitations for work with or around children <input type="checkbox"/> Health problem, but no limitations for work with or around children. Please explain in comments. <input type="checkbox"/> Health problem which would affect ability to care for children. (e.g. substance abuse, emotional/mental illness, lifting restrictions, prescription medication side effects). <i>Please explain in comments.</i>			
Comments: (Please use back of this form if additional space is needed.)			
Physician's Signature	Date	Telephone No.	Last Examination Date:
Address (Street Number and Name)	City	State	Zip Code