MEDICAL CLEARANCE REQUEST – CHILD CARE LICENSING

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO ➡

Licensing Consultant (Name, Address, Phone)
Licensing and Regulatory Affairs
Child Care Licensing
PO Box 30664
Lansing, MI 48909

License Application Type

☐ Child Care (Less Than 24-Hour Care)

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Telephone Number	
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the home listed above and to the Michigan Department of Licensing and Regulatory Affairs, Child Care Licensing, for the purpose of determining my suitability to provide or be associated with the care of children.

Date

Patient's Signature

Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- This individual is, or will be, caring for children in a child care setting and may be solely responsible for children birth to age 17.
- It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child and the quality and manner of his/her care.
- To assist us in this determination, you are being asked to answer the following.

Has this Person Been Tested for T.B.?	Date Tested (Required Only One Time)	Test Type	Results
☐ No ☐ Yes If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

☐ No physical/mental condition or health problem exists that would limit the ability to provide independent care of children (birth to age 17) in a child care setting.

☐ Physical/mental condition or health problem exists which would affect the ability to provide independent care of children (birth to age 17) in a child care setting, with or without reasonable accommodation. Explain in comments if reasonable accommodation may be needed.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: 1973 PA 116
RESPONSE: Voluntary
PENALTY: Application for licensure/registration may be denied.

LARA is an equal opportunity employer/program.