COLORADO
Department of Early Childhood

FOR STATE USE ONLY
License # _____
Specialist _____

Health Evaluation Form – Family Child Care Home

This section is to be completed by the Applicant:

The section below must be completed for <u>all</u> persons residing in the home. This form can be copied if necessary.

I authorize _____ to give the Department information about my
(Medical Provider's Name)

family's physical and mental condition.

1st Applicant _____ Signature _____

2nd Applicant _____ Signature _____

Address _____
Street City Zip Code

Date: _____ Phone Number: _____

This section is to be completed by the Medical Provider:

The above-named person is applying for a family care home license to care for unrelated children in the home. Please indicate below your opinion as to whether any of the residents of this home suffer from any physical, mental, or emotional illness or condition or any communicable disease which could adversely affect children in care. This information will be used for licensing purposes only.

Applicant name _____

Date of last visit _____

Is this patient under treatment for a chronic illness? ☐ Yes ☐ No

If yes, what is the diagnosis? _____

What medications are prescribed? _____

General assessment of patient's health _____

List below any physical, mental, or emotional conditions of the patient that could adversely affect non-related children in care _____

_____

Recommended date of next health evaluation for licensing purposes _____

OTHER ADULTS

Name _____ Date of last visit _____

Is this patient under treatment for a chronic illness? ☐ Yes ☐ No

If yes, what is the diagnosis? _____

What medications are prescribed? _____

General assessment of patient's health _____

List below any physical, mental, or emotional conditions of the patient that could adversely affect non-related children in care _____

_____

Licensing rules now permit medical providers to exempt family members from annual health evaluations if it is a part of a written plan.

Recommended date of next health evaluation for licensing purposes _____

CHILDREN

Child's name _____ Date of last visit _____

General condition of health _____

List below any physical, mental, or emotional conditions of the patient that could adversely affect non-related children in care _____

_____

Unless otherwise indicated here, the next health evaluation will be required in 2 years: _____
Alternative Date

Child's name _____

General condition of health _____

List below any physical, mental, or emotional conditions of the patient that could adversely affect non-related children in care _____

_____

Unless otherwise indicated here, the next health evaluation will be required in 2 years: _____
Alternative Date

Medical provider's name _____

Medical provider's signature _____

Address _____ Phone Number _____

Date _____