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| MEDICAL CLEARANCE REQUEST – CHILD CARE LICENSING | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Michigan Department of Licensing and Regulatory Affairs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child Care Licensing Bureau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **APPLICANT/LICENSEE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility/Home Name | | | | | | | | | | | | | | | | | | | | | | | License Number | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Facility/Home Address (Street Number and Name) | | | | | | | | | | | City | | | | | | | | | | | | State | | | Zip Code | | | |
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|  | | | | Licensing Consultant (Name, Address, Phone) | | | | | | | | |  | | | License Application Type | | | | | | | | | | | | | |
| PLEASE  MAIL TO | | | | Licensing and Regulatory Affairs  Child Care Licensing Bureau  PO Box 30664  Lansing, MI 48909 | | | | | | | | |  | | |  | 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 Bureau, 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 may be denied. | | | | | | | | | | | | **LARA is an equal opportunity employer/program.** | | | | | | | | | | | | | | | | | |