| FOR STATE USE ONLY |
| --- |
| License # |
| Licensing Specialist |

**Colorado Department of Human Services**
Division of Early Care and Learning
1575 Sherman Street, 1st Floor
Denver, CO 80203-1714
Telephone: (303) 866-5948
Fax: (303) 866-4453

## HEALTH EVALUATION FORM – FAMILY CHILD CARE HOME

This selection is to be completed by the applicant. The sections below must be completed for all persons residing in the home. This form can be copied if necessary.

I authorize _____ to give the above-name department information about my family's physical and mental condition.

Applicant 1: _____ Signature: _____
Print Name Sign Name

Applicant 2: _____ Signature: _____
Print Name Sign Name

Address: _____ Date: _____
Street

_____ Telephone Number: _____
City State Zip Code

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**TO BE COMPLETED BY THE MEDICAL PROVIDER:**

The above-named person is applying for a Family Child 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, condition, or any communicable disease which could adversely affect the children in their care. This information will be used for licensing purposes only.

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**APPLICANT NAME: _____**

Date you last saw patient? _____ Is patient under treatment for chronic illness? ☐YES ☐NO
If yes, what is the diagnosis? _____
What medications are prescribed? _____
General assessment of patient's health: _____
List below any emotional, mental, or physical conditions of the patient that could adversely affect non-related children in care:

_____

_____

Please indicate recommended date of next health evaluation for licensing purposes: _____

***Medical Providers: PLEASE SIGN ON THE BACK OF THIS FORM***

**OTHER ADULTS:**

Name: _____

Date you last saw patient? _____ Is patient under treatment for chronic illness? ☐YES ☐NO

If yes, what is the diagnosis? _____

What medications are prescribed? _____

General assessment of patient's health: _____

List below any emotional, mental or physical 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 part of a written plan.** Please indicate recommended date of next health evaluate for licensing purposes: _____

**CHILDREN:**

Child's Name: _____

General condition of patient's health: _____

List below any emotional, mental, or physical conditions of the patient that could adversely affect children in the home:

_____

_____

_____

**Unless otherwise indicated here, the next health evaluation will be required in two (2) years:** _____

Alternative Date

Child's Name: _____

General condition of patient's health: _____

List below any emotional, mental, or physical conditions of the patient that could adversely affect children in the home:

_____

_____

_____

**Unless otherwise indicated here, the next health evaluation will be required in two (2) years:** _____

Alternative Date

## *Medical Providers: PLEASE SIGN BELOW*

**Medical Provider's Name: _____ Telephone Number: _____**

**Medical Provider's Signature: _____ Date: _____**

**Address: _____**

Street City State Zip Code