Substitute Health Examination Form

TO BE COMPLETED BY STAFF		
Patient's Name:		Date of Birth:
Patient's Address:	City:	Zip:
Patient's Signature:		Date:

TO BE COMPLETED BY HEALTH CARE PROVIDER
The above-named patient is a registered family child care provider substitute in the state of New Jersey. New Jersey State regulations require a physician's statement verifying the individual is in good health, free from communicable disease and able to care properly for children placed in the home. The children enrolled in this program may include children from birth to 13 years of age. To assist us in evaluating the application, we are asking you to answer the questions below to the best of your knowledge.
Date of Physical Examination:
Is the patient in sufficient physical health to properly care for children? ☐Yes ☐No Remarks:
Is the patient is the free of communicable disease? ☐Yes ☐No Remarks:
Are you aware of any reason that the patient should not be left unsupervised with enrolled children, which may include children from birth to 13 years of age? ☐Yes ☐No If yes, please explain:

Physician Signature:	Date:	Physician Name:
Physician Office Address and Telephone:		

Clear Form