GOVERNMENT OF BERMUDA
Ministry of Health

MEDICAL CERTIFICATE FOR CARE PROVIDERS

This certificate is to establish that the patient named below is in good physical and mental condition as to not adversely affect the health or safety of those persons they care for.

PATIENT INFORMATION and AUTHORIZATION (To be completed by the PATIENT)

Name:	**Date of Birth:**

I authorize the release of this medical information to my potential employer and Ministry of Health appointed inspectors to ensure compliance with:

☐ the Day Care Centre Regulation 199 and/or Child Care Regulation Programme 's registration requirements.

Signature: **Date:**

MEDICAL INFORMATION (To be completed by PHYSICAN)

- This individual is or will be employed in a child care setting.
- It is necessary to establish that those providing care are in good physical and mental condition and will not to adversely affect the health or safety of a child.
- To assist us in this determination, you are being asked to answer the following.

1. Check to indicate general health status of patient:
If any are unchecked provide an explanation in comments section

☐ Free from active infections of communicable diseases
☐ Free from substance abuse
☐ Mentally fit and capable of caring for infants and toddlers

2. Check to indicate if your patient has the physical capacity to perform the functions of their post:

☐ **Yes**

☐ **No** Specify:_____

Can the provider perform the following for the period of time they would watch the children (i.e. 7 to 8 hours). Check all that apply:

- ☐ Sit on the floor
- ☐ Stand and walk
- ☐ Lift up to 30 lbs.
- ☐ Bend down to the floor
- ☐ Squat
- ☐ Reach up and down
- ☐ Carry up to 30 lbs.
- ☐ Push
- ☐ Pull
- ☐ See and hear without difficulty

_____

_____

_____

☐ Drive a car, if necessary._____

3. Check to indicate patient's current vaccine status (As known. No testing required): *This to prompt discussion of identifying who may be at risk and advise if vaccines are recommended due to care giver or care recipient(s) risk factors. Additionally it documents history in event of outbreak.*	☐ Influenza vaccine Date:_____ ☐ Measles, Mumps, Rubella Date:_____ ☐ Varicella (chickenpox): Date:_____ ☐ Polio: Date_____ ☐ Hepatitis B: Date_____ ☐ Tetanus, Diphtheria, Pertussis Date:_____ ☐ Other (see Adult Immunization Schedule)_____
Comments:	
Date:	**Physician Signature:**
Contact Number:	**Print Name:**