GOVERNMENT OF BERMUDA

Department of Health

MEDICAL CLEARANCE REQUEST FORM

APPLICANT INFORMATION

Name		Registration Number:
Address	Parish	Code

RELEASE OF INFORMATION (To be completed by the applicant)

I authorize the release of my medical information to the Director of Health, for the purpose of determining my suitability to provide or be associated with the care of children.	**Date**
	Applicant Signature

MEDICAL INFORMATION (To be completed by your physician)

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, please indicate if the applicant is:

- ☐ Free from communicable disease?
- ☐ Free from substance abuse?
- ☐ Mentally fit and capable of caring for infants and toddlers?
- ☐ 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
- ☐ Appropriately immunized? (as per the Adult Immunization Schedule)

Comments (Please use back of this form if additional space is needed)		
Physician's Signature	Date	Telephone Number
Print Name		

Child Care Quality Assurance Programme
Ministry of Health, Continental Building, 25 Church Street, Hamilton HM12, Bermuda
Phone: (+1 441) 278-4900 **Email:** childcare@gov.bm