DCC-95A-spa
(R. 08/2019)

**COMMONWEALTH OF KENTUCKY**
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

N

# Declaración de salud

Nombre (Primer nombre, Segundo nombre, Apellido) | Fecha de nacimiento | Teléfono

Dirección: Calle | Ciudad | Estado | Código Postal

**AUTORIZACIÓN PARA LA REVELACIÓN DE INFORMACIÓN MÉDICA:** Autorizo la revelación de esta información exclusivamente para mi solicitud como proveedor de cuidado infantil.

Firma del solicitante de cuidado infantil | Fecha

**(Esta sección será llenada por el profesional de atención médica)**

**THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL**

*As part of the application process for approval as a child care provider, a statement from a physician, physician's assistant, advanced registered nurse practitioner, or registered nurse under the supervision of a physician, is required to address the following:*

1. Do you have reason to believe the applicant has a communicable or infectious disease that would present a health or safety risk to a child placed in the applicant's care? ☐**YES** ☐**NO**

2. Has the applicant previously had or does the applicant currently have a medical condition that would present a health or safety risk to a child placed in the applicant's care? ☐**YES** ☐**NO**

3. Does the applicant have a physical limitation, mental illness, alcohol or drug problem, significant history of physical or mental illness, or other health condition that would interfere with the applicant's ability to provide child care? ☐**YES** ☐**NO**

4. Does the applicant currently take prescription medication that would interfere with the applicant's ability to provide child care? ☐**YES** ☐**NO**

5. Would responsibility for a child or children pose a potential risk to the applicant's health? ☐**YES** ☐**NO**

Physician's/Health Care Professional's Signature or Stamp | Title | Date

Address | Phone Number