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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | LICENSING DIVISION (LD)**Applicant Medical Self Report****CONFIDENTIAL** |
| **Applicant Name:**  |
| **Medical History** |
| What is the date of your last physical exam (if known)?  |
| Current and/or past diagnosis – Have you ever been diagnosed with any of the following conditions? Please check all that apply and provide comments, if applicable. *For license renewal, please include the last three (3) years.* |
| [ ]  Heart Disease: [ ]  Cancer: [ ]  Chronic Medical Condition: [ ]  Hereditary Condition(s): [ ]  Seizure Disorder: [ ]  Orthopedic Problems: [ ]  Autoimmune Disease:  | [ ]  Stroke: [ ]  Mental Health Condition: [ ]  Kidney Disease[ ]  Allergies[ ]  Diabetes[ ]  Thyroid Disease[ ]  Chronic Pain | [ ]  Hypertension[ ]  Heart Attack[ ]  Impaired Hearing[ ]  Respiratory Condition[ ]  Impaired Sight[ ]  Other Condition or Injury:  |
| Are you currently under a physician’s care for any of the diagnoses or injuries listed above? [ ]  No [ ]  YesIf yes, please list diagnoses/injuries: Have you ever participated in counseling (e.g. individual, family, group, etc.)? *For license renewal, please include the last three (3) years.*[ ]  No [ ]  Prefer to discuss in person [ ]  Yes (optional comments)  |
| Please list any surgeries or hospital stays you have had and their approximate date. Type of surgery/reason for hospitalization Date  |

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| Describe your frequency and type of tobacco use, if any:  |

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| Describe your frequency and type of recreational marijuana/THC use, if any:  |

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| Describe your frequency and type of alcohol use, if any:  |

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| Do you have any limitations or restrictions on physical activity? [ ]  No [ ]  YesIf yes, please describe: |

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| **Medications** |
| Please list all medications you are currently taking including over the counter medications and medical marijuana. Additional medications can be listed in an attachment.  |
| Name of medication | Dosage and frequency | Condition prescribed for | Side Effects – Note any that may impact the care of children |
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| **Competence** |
| Do you consider yourself mentally, physically, and emotionally competent to care for children? [ ]  Yes [ ]  NoIf no, please explain: |

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| **Additional Comments** |
| Do you have any additional comments you want to include in your medical history? [ ]  Yes [ ]  No |

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| **Signature** |
| I declare that the above information is true and correct to the best of my knowledge. |
| APPLICANT NAME | DATE OF BIRTH |
| APPLICANT SIGNATURE | DATE |