|  |  |  |  |
| --- | --- | --- | --- |
| 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  Yes  If 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 | | | |

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

|  |
| --- |
| Do you have any limitations or restrictions on physical activity?  No  Yes  If yes, please describe: |

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Competence** | | | |
| Do you consider yourself mentally, physically, and emotionally competent to care for children?  Yes  No  If no, please explain: | | | |

|  |
| --- |
|  |

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

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **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 |