STAFF HEALTH ASSESSMENT

3270.151, 3280.151, 3290.151

CHILD DAY CARE CENTERS • GROUP DAY CARE HOMES • FAMILY DAY CARE HOMES

NAME OF PERSON EXAMINED

DID YOU CONDUCT A PHYSICAL EXAMINATION? ☐ YES ☐ NO

(The physical examination should include a functional assessment of vision, hearing, and a systems review looking for conditons that might affect performance or predispose this individual to occupational injury related to lifting, frequent hand washing, the stress of caring for groups of children, driving vehicles, food preparation, facility maintenance and exposure to the common infections of childhood.)

DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES? ☐ YES ☐ NO

(If yes, attach separate sheets to describe the condition and the risk it might pose to others exposed to this individual.)

PLEASE LIST ANY INFORMATION REGARDING THIS INDIVIDUAL'S MEDICAL CONDITION THAT MIGHT THREATEN THE HEALTH OF CHILDREN OR PROHIBIT THE INDIVIDUAL FROM PROVIDING ADEQUATE CARE TO CHILDREN.

IN YOUR ASSESSMENT, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE? ☐ YES ☐ NO

(If "no," please explain your answer on a separate sheet.)

TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX METHOD

DATE TEST APPLIED	DATE TEST READ

PHYSICIAN'S INTERPRETATION OF TUBERCULIN TEST RESULTS	DATE INTERPRETATION MADE	☐ POSITIVE ☐ NEGATIVE

IF SKIN TEST POSITIVE:

REPORT OF CHEST X-RAY (Attach a copy of the report.)	DOES THIS INDIVIDUAL NEED CHEMOPROPHYLAXIS? ☐ YES ☐ NO

DATE _____ SIGNATURE _____ MD/DO CRNP

PRINTED NAME _____ TELEPHONE NUMBER _____

ADDRESS _____