

STAFF HEALTH ASSESSMENT

NAME: _____ DOB: _____

Type of Activity In Child Care (Check all applicable) Caring for children Desk Work
 Adult Member of Household Food Preparation Driver of Vehicle Facility Maintenance

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH ASSESSMENT

PART I – MEDICAL HISTORY – Does this person have any of the following medical problems?

	Yes*	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		
History of epilepsy?		
Diabetes?		
Current drug or alcohol dependency?		
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		
Does this person have any special medical problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children? If yes, explain on reverse of form.		
Speech disorder?		
Significant physical findings/chronic medical condition or physical impairment?		

*EXPLAIN ALL "YES" RESPONSES ON REVERSE OF FORM, GIVING PLAN FOR FOLLOW-UP, IF ANY.

PART II – As shown by physical examination, does the individual have

	Yes	No*
At least 20/20 combined vision, corrected by glasses if needed?		
Normal hearing?		
Normal blood pressure?		

*EXPLAIN ALL "NO" RESPONSES ON REVERSE OF FORM

PART III – Communicable diseases – Does this person have a communicable disease which would prohibit him/her from working in a child care facility?

Yes No If yes, please comment: _____

Tuberculosis Certification <i>(if medically recommended or required by the Local Health Officer)</i>		
TYPE OF TEST:	READING:	DATE:

<p>Immunization Status</p> <p>Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV. Immunization status reviewed: Yes No</p> <p>Comments: _____</p> <p>_____</p>
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Name & Address of Health Care Provider _____ Telephone Number _____

Signature of Health Care Provider _____ Date of Examination _____