STAFF HEALTH APPRAISAL

Child Day Care Centers • Group Day Care Homes • Family Day Care Homes

THIS SECTION TO BE COMPLETED BY THE EMPLOYE

NAME AND ADDRESS OF INDIVIDUAL EXAMINED

NAME OF EMPLOYER | EMPLOYER'S TELEPHONE NO.

EMPLOYER'S ADDRESS

PURPOSE OF EXAMINATION
- ☐ INITIAL EMPLOYMENT
- ☐ ANNUAL RE-EXAMINATION

TYPE OF ACTIVITY IN DAY CARE (Check all applicable)
- ☐ CARING FOR CHILDREN
- ☐ FOOD PREPARATION
- ☐ DESK WORK
- ☐ DRIVER OF VEHICLE
- ☐ FACILITY MAINTENANCE

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

PART I - As shown by physical examination, does the individual have:	YES	NO		YES	NO
1. At least 20/40 combined vision, corrected by glasses, if needed?			5. Normal respiratory system?		
2. Normal hearing?			6. Normal skin?		
3. Normal blood pressure?			7. Normal neuro musculoskeletal systems?		
4. Normal cardiovascular system?			8. Normal endocrine system?		

EXPLAIN ALL "NO" RESPONSES ON REVERSE OF FORM, GIVING PLAN FOR FOLLOW-UP

PART II - Does this individual have any of the following medical problems:	YES	NO		YES	NO
9. History of myocardial infarction, angina pectoris, coronary insufficiency?			13. Inadequate immune status (Td, measles, mumps, rubella)?		
10. History of epilepsy?			14. Need for more frequent health visits or sick days than average for age?		
11. Diabetes?			15. Current drug or alcohol dependency?		
12. Thyroid or other metabolic disorders?			16. Disabling emotional disorder?		
17. 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.					

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

18. Does this individual have any special medical problems which might interfere with the health of the children or which might prohibit the individual from providing adequate care for the children? If yes, explain on reverse of form.		

PART III - REQUIRED TEST FOR TUBERCULOSIS TUBERCULIN SKIN TEST BY EITHER INTRACUTANEOUS MAMTOUX TWO STEP METHOD OR PERCUTANEOUS MULTIPLE PUNCTURE METHOD.

PHYSICIANS REPORT OF TUBERCULIN TEST RESULTS

19. INTRACUTANEOUS MANTOUX TEST METHOD	REPORT OF FIRST TEST	REPORT OF SECOND TEST IF NONSIGNIFICANT ON FIRST TEST 1 TO 3 WEEKS LATER
Name of antigen used and manufacture.		
Lot number.		
Dose of purified protein derivative.		
Date on which test was applied.		
Date on which test read.		
Measurement of Widest Diameter of induration in millimeters.		

If Positive:

DATE OF REPORT OF 14 x 17 CHEST X-RAY (attach copy of report)	OTHER STUDIES DONE TO RULE OUT TUBERCULOSIS DISEASE

20. PERCUTANEOUS MULTIPLE PUNCTURE TEST METHOD	
NAME OF PRODUCT USED AND MANUFACTURER	LOT NUMBER
DATE ON WHICH TEST WAS APPLIED	DATE ON WHICH TEST READ
DESCRIPTION OF REACTION*	
If Vesticulated:	
DATE AND REPORT OF 14 x 17 CHEST X-RAY (attach copy of report)	OTHER STUDIES DONE TO RULE OUT TUBERCULOSIS DISEASE

*NOTE: ANY DURATION WITHOUT VESICULATION MUST BE RETESTED USING THE MANTOUX METHOD.

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE.

REFERRED FOR PREVENTIVE ANTI-TUBERCULOSIS CHEMOTHERAPY? (✓) ☐ YES ☐ NO

Physician Signature | *Physician Name (Print)*

Physician Address | *Date*

PATIENT AUTHORIZATION

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. Unless prohibited by law, I authorize the physician or other person to disclose any knowledge or information pertaining to my health. I understand that any false or misleading statements may cause termination of my employment.

Patient Signature | *Date*