ADULT HEALTH APPRAISAL FOR CHILD CARE

NAME _____ **DATE OF BIRTH** _____

Type of Activity in Child Care (Check all applicable)

[ ] Caring for Children [ ] Adult Member of Household [ ] Food Preparation [ ] Driver of Vehicle [ ] [ ] Desk Work
[ ] Facility Maintenance [ ] Other

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
1. At least 2020 combined vision, corrected by glasses, if needed?		
2. Normal hearing?		
3. Normal blood pressure?		
4. Normal cardiovascular system?		
5. Normal respiratory system?		
6. Normal skin?		
7. Normal neuro musculoskeletal systems?		
8. Normal endocrine system?		

EXPLAIN ALL "NO" RESPONSES ON REVERSE OF FORM

Part II - Is the individual free from communicable tuberculosis as shown by

	Yes	No
9. Negative skin test results within the past year?		
10. Positive skin test followed by one negative x-ray and an asymptomatic history at this health appraisal?		

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

Part III - Does this individual have any of the following medical problems:

	Yes	No
11. History of myocardial infarction, angina pectoris, coronary insufficiency?		
12. History of epilepsy?		
13. Diabetes?		
14. Thyroid or other metabolic disorders?		
15. Inadequate immune status (Td, measles, mumps, rubella)?		
16. Need for more frequent health visits on sick days than average for age?		
17. Current drug or alcohol dependency?		
18. Disabling emotional disorder?		
19. Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect 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

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

Name and address of licensed physician Telephone Number

Signature of Physician Date of Examination