teach, explore, inspire... green.™

kidz go eco LLC

PERSONNEL HEALTH

Name of Child Care Program: _____

Employee's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

My signature below authorizes the release of the following medical information to the above named child care program and to the bureau of child care licensing.

Signature: _____ Date: ____ / ____ / _____

The remainder of this form must be completed by a licensed health practitioner.

Name of Licensed Health Practitioner: _____

Address: _____ City: _____ State: _____ Zip: _____

Tuberculin Test (required for high risk individuals only) Date of Test: ____ / ____ / _____

Tuberculin Skin Test Type (Mantoux Recommended): _____

Date of Interpretation: _____ Findings: _____ (mm in duration)

Positive Tuberculin Skin Test must be followed up by a chest x-ray

Date of Chest X-Ray: _____ Findings: _____

Physician's Comments: _____

IMMUNIZATIONS

Rubella Date of Immunization: _____ or Date of Titer: _____

Measles (Rubeola) Date of Immunizations: _____ or Date of Titer: _____

Tetanus/Diphtheria (TD) Date of Immunizations: _____ or Date of Titer: _____

Date of Disease (must have been physician diagnosed): _____

Hepatitis B Date of Immunization Series Completed: _____

PERSONNEL HEALTH

Please indicate by checking below, any current or previous illness which could impact the examinee's ability to adequatley care for children.

	YES	NO	UNKNOWN
Tuberculosis or Other Pulmonary Problems	☐	☐	☐
Heart Disease	☐	☐	☐
Diabetes	☐	☐	☐
Other Chronic Disease	☐	☐	☐
Mental or Emotional Disturbance	☐	☐	☐
Fainting and Dizzy Spells	☐	☐	☐
Epilepsy or Neurological Condition	☐	☐	☐
Serious Defects of Bones & Joints	☐	☐	☐
Other Communicable Disease	☐	☐	☐
Alcohol or Drug Dependency	☐	☐	☐

Specifics regarding any of the above conditions: _____

_____

Please list any medication currently prescribed which could effect his/her ability to care for children:

_____

_____

Impression of present state of health: _____

_____

Recommendation - Based upon the above information, I recommend the following: *(please check one)*

☐ This patient has no apparent health problems which would prohit his/her employment caring for children.

☐ Because of the conditions noted above, I do not recommend that the examinee be employed caring for children.

Date of Examination: ____ / ____ / _____ Today's Date: ____ / ____ / _____

Signature of Licensed Health Practitioner: _____