kidz go eco NATURE SCHOOL

PERSONNEL HEALTH

Must provide a copy of current doctor's imminization records.

Name of Child Care Program:____

Employee's Name:____

Address:____ City:_______________ State:______________

Zip Code:____________ Phone:____

My signature below authorizes the release of the following medical information on 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 PRACTIONER.

Name of Licensed Health Practionor:____

Address:________________________________ City:_______________ State:____________Zip Code:__________

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

Date of Chest X-Ray:________________________ Findings:____

Physician's Comments:____

IMMUNIZATIONS

Rubella	Date of Immuniztion:____________________	or Date of Titer:_______________
Measles (Rubeola)	Date of Immuniztion:____________________	or Date of Titer:_______________
Tetanus/Diphtheria (TD)	Date of Immuniztion:____________________	or Date of Titer:_______________
	Date of Disease (must have been phsician diagnosed):___________________	
Hepatits B	Date of Immuniztion Series Completed:________________________________	

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

	YES	NO	UNKOWN
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 Dependecy	☐	☐	☐

Specifics regarding any of the above conditions:

____

____

Please list any medication currenlty 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 prohibit 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:____

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