**ADULT HEALTH APPRAISAL FOR CHILD CARE**

**PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF HEALTH EXAMINATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 APPRAISAL**

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| --- | --- | --- |
| 1. As shown by physical examination, is this individual able to perform the tasks of providing care to children? | **Yes** | **No** |
| **If no,** please explain: | | |
| 1. Does this individual have any special medical conditions that might interfere with the health of the children or might impact the level of care the individual can provide to children? | **Yes** | **No** |
| **If yes,** please explain:  Describe any reasonable accommodations that may be required, if applicable: | | |
| 1. Is this individual free from communicable tuberculosis?   **Determination based on (check one):**  A negative skin test or TB risk assessment within the past 12 months. 󠆸󠆸 Yes 󠆸󠆸 No  OR  A positive skin test followed by one negative x-ray and an asymptomatic history at this health  appraisal. 󠆸󠆸 Yes 󠆸󠆸 No 󠆸 | **Yes** | **No** |
|  | |
| **IF BOTH ARE "NO" RESPONSES, PLEASE EXPLAIN AND PROVIDE PLAN FOR FOLLOW-UP:** | | |

PRINT Name of Health Care Professional Licensed to Perform Health Appraisals Telephone Number

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Signature of Health Care Professional Licensed to Perform Health Appraisals Date