

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

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:		
2. 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:		
3. Is this individual free from communicable tuberculosis?	Yes	No
Determination based on (check one): A negative skin test or TB risk assessment within the past 12 months. <input type="checkbox"/> Yes <input type="checkbox"/> No OR A positive skin test followed by one negative x-ray and an asymptomatic history at this health appraisal. <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

PRINT Address of Health Care Professional Licensed to Perform Health Appraisals _____

Signature of Health Care Professional Licensed to Perform Health Appraisals _____ Date _____