

# 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 20/20 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 or TB risk assessment within the past year?		
10. Positive skin test followed by one negative x-ray and an asymptomatic history at this health appraisal?		

**IF BOTH "NO" RESPONSES, EXPLAIN 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 his or 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**

**Child Care Statement**

	Yes	No
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 \_\_\_\_\_