Child Care Staff Health Assessment

******** Employer should complete this section. ********

Name of person to be examined: _____

Employer for whom examination is being done: _____

Employer's Location: _____ Phone number: _____

Purpose of examination: ☐pre-employment (with conditional offer of employment) ☐annual re-examination

Type of activity on the job: ☐lifting, carrying children ☐close contact with children ☐food preparation ☐desk work ☐driver of vehicles ☐facility maintenance

****** Part I and Part II below must be completed and signed by a licensed physician or CRNP. ******

Based on a review of the medical record, health history, and examination, does this person have any of the following conditions or problems that might affect job performance or require accommodation?

Date of exam: _____

Part I:Health Problems (circle)

Visual acuity less than 20/40 (combined, obtained with lenses if needed)? ..... yes ..... no
Decreased hearing or difficulty functioning in a noisy environment (less than 20 db at 500, 1000, 2000, 4000 Hz)? ..... yes ..... no
Respiratory problems (asthma, emphysema, airway allergies, current smoker, other)? ..... yes ..... no
Heart, blood pressure, or other cardiovascular problems? ..... yes ..... no
Gastrointestinal problems (ulcer, colitis, special dietary requirements, obesity, other)? ..... yes ..... no
Endocrine problems (diabetes, thyroid, other)? ..... yes ..... no
Emotional disorders or addiction (depression, substance dependency, difficulty handling stress, other)? ..... yes ..... no
Neurologic problems (epilepsy, Parkinsonism, other)? ..... yes ..... no
Musculoskeletal problems (low back pain or susceptibility to back injury, neck problems, arthritis, limitations on activity)? ..... yes ..... no
Skin problems (eczema, rashes, conditions incompatible with frequent handwashing, other)? ..... yes ..... no
Immune system problems (from medication, inherent susceptibility to infection, illness, allergies)? ..... yes ..... no
Need for more frequent health visits or sick days than the average person? ..... yes ..... no
Other special medical problem or chronic disease that requires work restrictions or accommodation? ..... yes ..... no

Part II: Infectious Disease Status

Female of childbearing age susceptible to CMV or parvovirus? ..... yes ..... no
Immunizations now due/overdue for:
- Tdap* ..... yes ..... no
- MMR (2 doses for persons born after 1989; 1 dose for those born in or after 1957) ..... yes ..... no
- polio (OPV or IPV in childhood) ..... yes ..... no
- hepatitis B (3 dose series) ..... yes ..... no
- varicella (2 doses or had the disease) ..... yes ..... no
- influenza ..... yes ..... no
- pneumococcal vaccine ..... yes ..... no

*Reference: Centers for Disease Control and Prevention. 2006. Preventing Tetanus, Diphtheria, and Pertussis Among Adults: Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine. *MMWR* 55(RR17): 1-33.

Evaluation of tuberculosis status shows a risk for communicable TB? ..... yes** ..... no

☐ Tuberculin Skin Test (TST) ☐ Interferon-Gamma Release Assay (IGRA) Test Date: _____ Result: _____
(Check Test Used)

Transmission of tuberculosis infection should be controlled by requiring all adolescents and adults who are present while children are in care to have their tuberculosis status assessed with a tuberculin skin test (TST) or interferon-gamma release assay (IGRA) blood test before caregiving activities are initiated. In people with a reactive TST or positive IGRA, chest radiography without evidence of active pulmonary disease and/or documentation of completion of therapy for latent tuberculosis infection (LTBI) or completion of therapy for active disease should be required.

**Health professions should consult the current edition of *Red Book: Report of the Committee on Infectious Diseases* (www.aapredbook.org) for guidance on TB screening.
For current adult immunization requirements see: www.cispimmunize.org www.aapredbook.org; and www.cdc.ogv/vaccines/recs/schedules/default.htm.

Please attach additional sheets to explain all "yes" answers above. Include the plan for follow up.

_____ _____ _____ MD DO CRNP
(Date) (Signature) (Printed last name) (Title)

Phone number of physician or CRNP: _____

I have read and understand the above information.

_____ _____
(Date) (Patient's Signature)

Reference: Pennsylvania Chapter, American Academy of Pediatrics. 2002. *Model child care health policies.* 4th ed. Washington, DC: National Association for the Education of Young Children.
This form was adapted from *Model Child Care Health Policies*, 2002, by the Early Childhood Education Linkage System (ECELS), a program funded by the Pennsylvania Depts. of Health & Public Welfare and contractually administered by the PA Chapter, American Academy of Pediatrics.