



Child Care Provider Physical Examination Report

Child Care Center Personnel • Child Development Home Providers

Name	Date of Examination
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Patient may:

- ✓ have very frequent contact with children (infant through school-age) in care.
- ✓ be responsible for children’s physical care and social development during day and nighttime hours.
- ✓ need to lift children, bend, and stand for long periods of time.

Child Care Provider Health Concerns (Please check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Illegal or prescription drug abuse |
| <input type="checkbox"/> Breathing problems (asthma, emphysema) | <input type="checkbox"/> Neurologic problems (epilepsy, Parkinsonism, other) |
| <input type="checkbox"/> Diabetes or problems like thyroid, other | <input type="checkbox"/> Smoking or alcohol use |
| <input type="checkbox"/> Heart, blood pressure problems | <input type="checkbox"/> Susceptibility to infection, illness |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Stomach or bowel problems |
| <input type="checkbox"/> Skin problems (eczema, rashes, conditions incompatible with frequent hand washing, other) | |
| <input type="checkbox"/> Emotional or nervous problems (depression, difficulty handling stress) | |
| <input type="checkbox"/> Musculoskeletal problems (low back pain, susceptibility to back injury, neck problems, arthritis) | |
| <input type="checkbox"/> Hearing or difficulty hearing in a noisy environment | |
| <input type="checkbox"/> Other (explain): _____ | |

Immunization Status

All child care employees and providers shall consult with their physician regarding the receipt of age appropriate immunizations in accordance with the current Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. Individuals involved in the provision of child care often come in contact with very young children, whom may or may not be fully immunized against vaccine-preventable diseases. It is essential every child care employee and provider discuss with their physician the benefits and risks associated with receiving or not receiving all ACIP age appropriate immunizations before becoming involved in a child care setting.

(PHYSICIAN MUST CHECK ONE AND DATE)

- Patient’s immunization history was reviewed and patient is current with all ACIP recommended immunizations.
- Patient received consultation regarding the receipt of age appropriate immunizations in accordance with the current ACIP recommended immunization schedule and declined the following recommended vaccinations:

Date: _____

Tuberculosis Screening

All child care employees and providers shall receive a baseline screening for Tuberculosis. Baseline screening shall consist of two components:

1. Assessing for current symptoms of active TB disease.
2. Screening for risk factors associated with TB.

Those individuals identified as belonging to a defined high-risk group or who have signs or symptoms consistent with TB disease shall be evaluated for TB infection and TB disease.

(PHYSICIAN MUST COMPLETE AND CHECK AND DATE BOTH BOXES)

TB signs and symptoms screen completed Date: _____

TB risk factor screen completed Date: _____

**** Tuberculosis medical consultation and TB medications can be accessed by calling the Iowa Department of Public Health, Tuberculosis Control Program at 515-281-8636 or 515-281-7504.**

Other Communicable Diseases and Overall Health Status

Does the individual have a known communicable disease or other health conditions that poses a threat to the health, safety, or well-being of children? Yes No **(If yes, describe in detail below.)**

Does the child care provider have a condition that limits the provider's ability to safely supervise or evacuate multiple dependent children in case of emergency? Yes No **(If yes, describe in detail below.)**

Conclusion

- Individual may be involved with child care
- Individual may be involved with child care, with the following accommodations and restrictions (please describe below)
- Individual may not be involved with child care

Necessary Accommodations or Restrictions to Meet the Demands of Providing Child Care (Please detail.)

Health Care Provider Signature	Date
Mailing Address	Telephone
Provider Type: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> ARNP	Iowa License Number