

CHILD CARE PROVIDER HEALTH FORM

Name: _____ Date: _____

Type of essential job functions:

- close contact with children lifting, carrying children or equipment up to 40 pounds
- food preparation driver of vehicles desk work facility maintenance

To be completed by the health care provider:

Does this person have any other limiting condition(s) that would prevent him or her from working in a child care setting in the above activities: yes no

Is this person current for all immunizations that you routinely recommend for adults? yes no

If yes, please explain: _____

Based upon my evaluation (select one)

- Applicant can perform the essential functions of the job without direct threat to the health and safety of self or others.
- Applicant can perform the essential functions of the job without direct threat to the health and safety of others if the following restrictions can be accommodated:

Unless otherwise required by the health care provider this health form must be completed every two years. Please indicate the frequency of this assessment:

- Yearly Every two years Other, describe _____

Health Care Provider Printed Name _____

Health Care Provider Signature _____ Date _____

Staff Signature _____ Date _____