CHILD CARE PERSONNEL HEALTH FORM

NAME OF CHILD CARE PROGRAM: ____________________________________________________________

NAME & ADDRESS OF EMPLOYEE: __________________________________________________________

________________________________________________________

________________________________________________________

____________________________________________________________________________________

EMPLOYEE SIGNATURE           DATE SIGNED

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH PRACTITIONER.

TUBERCULIN TEST (REQUIRED FOR HIGH RISK INDIVIDUALS ONLY)
(If you have questions about who may be high risk, you may contact the TB Program for information at 1-800-852-3345, Ext. 4496 in NH, or outside NH at 603-271-4496)

TUBERCULIN SKIN TEST TYPE (MANTOUX RECOMMENDED): ___________________ DATE OF TEST __________

DATE OF INTERPRETATION ___________________ FINDINGS: ___________________ (mm induration)

Positive tuberculin skin test must be followed up by a chest X-ray and referral to a NH TB Program (271-4496)

DATE AND FINDINGS OF CHEST X-RAY: __________________________________________________________

PHYSICIAN’S COMMENTS: __________________________________________________________________

IMMUNIZATIONS: ITEMS 1 THROUGH 4 ARE RECOMMENDED, NOT REQUIRED BY LICENSING RULES

1. RUBELLA: DATE OF IMMUNIZATION: ___________________ OR DATE OF TITER: ___________________

2. MEASLES (RUBEOLA): DATE OF IMMUNIZATION(S): ___________________ OR DATE OF TITER: ___________________

   DATE OF DISEASE (MUST HAVE BEEN PHYSICIAN DIAGNOSED): ___________________

3. TETANUS/DIPHTHERIA/PERTUSSIS (TDAP—PREFERRED) OR TETANUS/DIPHTHERIA (TD): DATE OF IMMUNIZATION: ___________________

4. HEPATITIS B: DATE IMMUNIZATION SERIES COMPLETED: ___________________

IMPRESSION OF PRESENT STATE OF HEALTH: __________________________________________________________________

Because of the conditions noted above I do not recommend that the examinee be employed caring for children. (If additional space is needed, please use reverse side of form)

DATE OF EXAMINATION (IF DIFFERENT THAN THE DATE SIGNED BELOW): ___________________

BY SIGNING BELOW I HEREBY CERTIFY THAT THIS PATIENT HAS NO APPARENT HEALTH PROBLEMS THAT WOULD PROHIBIT HIS/HER EMPLOYMENT Caring for children UNLESS THE BOX ABOVE IS CHECKED.

SIGNATURE OF LICENSED HEALTH PRACTITIONER                   DATE SIGNED

PLEASE LIST ANY MEDICATION CURRENTLY PRESCRIBED, WHICH COULD EFFECT HIS/HER ABILITY TO CARE FOR CHILDREN:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SPECIFICS REGARDING ANY OF THE ABOVE CONDITIONS:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

PLEASE TYPE OR PRINT NAME AND ADDRESS OF LICENSED HEALTH PRACTITIONER

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Effective 11/2017