CHILD CARE STAFF HEALTH ASSESSMENT

(55 Pa. Code §§3270.151, 3280.151 and 3290.151)

NAME OF PERSON EXAMINED (Please print)	REASON FOR EXAMINATION
	☒ Initial employment in child care ☐ Biennial re-examination

THIS SECTION TO BE COMPLETED BY EMPLOYER

This physical examination is for the purpose of employment in a child care facility. The types of activities this individual will be doing are as follows (please check all that apply):

☐ Lifting, carrying children
☒ Close interaction with children
☐ Food preparation
☐ Desk work
☐ Driver of vehicle(s)
☐ Facility maintenance
☐ Other – describe below:

THIS SECTION TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)

1. DID YOU CONDUCT A PHYSICAL EXAMINATION? ☐ **YES** ☐ **NO**

The physical examination should include a functional assessment of vision and hearing and a systems review looking for conditions that might affect performance or predispose this individual to occupational injury relating to the type of activities required by the job (see type of job listed above.) Conditionals also include frequent hand washing, the stress of caring for groups of children, ability to actively supervise children, and exposure to the common infections of childhood. Please take note that substance abuse should be considered in determining suitability to provide child care.

2. DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES? ☐ **YES** ☐ **NO**

If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.

3. BASED ON YOUR FINDINGS FOR #1 AND #2 ABOVE AND OTHER INFORMATION GATHERED DURING YOUR EXAMINATION, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE? ☐ **YES** ☐ **NO**

IF YOU ANSWERED "NO" TO QUESTION #3, please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of children or prohibit the individual from providing safe and adequate care to children. Please attach separate pages as needed.

DATE	SIGNATURE	TITLE
TELEPHONE NO.	PRINTED NAME	
ADDRESS		

TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX OR INTERFERONGAMMA RELEASE ASSAY BLOOD TEST METHOD

Please note: The child care facility regulations require tuberculosis testing by Mantoux method or the interferongamma release assay (IGRA) blood test at initial employment in a child care setting. Subsequent testing is not required unless directed by a physician, physician's assistant, CRNP, the Department of Health or a local health department.

MANTOUX TEST DATE:	**RESULTS:** ☐ **POSITIVE** ☐ **NEGATIVE**
IF SKIN TEST IS POSITIVE:	**REPORT OF CHEST X-RAY** (Please attach an official radiology report)
	DOES THIS INDIVIDUAL NEED CHEMOPROHPHYLAXIS? ☐ **YES** ☐ **NO**

Please note: For the purposes of meeting the child care facility regulations, a person with a positive tuberculin skin test or blood test and a negative x-ray is not required to have further tuberculosis testing or x-rays, unless the person is exposed to an active case of tuberculosis or the person develops a productive cough which does not respond to medical treatment within 14 days.

JCC Summer Day Camp

Physical Examination Report

TO BE COMPLETED BY STAFF MEMBER:

Name: _____ Telephone:_____

Address: _____ City: _____ State:_____ Zip:_____

Birthdate: _____ Sex: _____ Age: _____

Emergency Information

Name: _____ Cell Phone_____Home Phone:_____

Address: _____ City: _____ State:_____ Zip:_____

I, hereby, give the Camp Nurse permission to treat in case of emergency:

Signature of Camp Staff: _____ Date:_____

Signature of Parent if Staff Member is under 18:_____Date:_____

TO BE COMPLETED BY PHYSICIAN:

Height:_____ Weight:_____ General Health:_____

Heart:_____Rate:_____ Rhythm:_____ Abnormalities:_____

Pulse: Pre-Exertion_____ After Exertion _____ Blood Pressure_____

Are there any camp activities to be restricted? No / Yes If yes, provide reason_____
Swimming _____Sleep outs_____ Diving_____ Athletics_____Hiking_____Other_____

Do you feel this person is physically able to work with active children all day? No / Yes

Presently receiving medical treatment? No / Yes If yes, please explain _____.

Will staff member's ability be impaired by use of medication? No / Yes If yes, please explain _____
_____.

Allergies:

☐Hay Fever ☐Ivy Poisoning ☐Asthma ☐Bees ☐Penicillin ☐Tree Nuts ☐Peanuts ☐Gluten/Wheat

☐Other Drugs _____☐Other Food_____ ☐Other_____

Please list the date of the last **Tetanus** shot: _____/_____