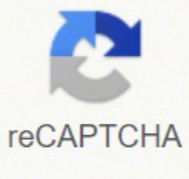




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Next

Medical examination report for caregivers and staff



MEDICAL EVALUATION

NAME OF PATIENT		DOB	
PRESENT ADDRESS			
CITY	STATE	ZIP	TELEPHONE
REASON FOR EVALUATION: <input type="checkbox"/> Pre-Admission <input type="checkbox"/> Annual <input type="checkbox"/> Possible change in patient's condition <input type="checkbox"/> Other (Describe)			
1. Current Diagnosis(es)			
2. Physical Limitations			
3. Mental Health Limitations			
4. Treatment/therapies (Describe medical services or nursing care or treatment needed.)			
5. Supportive Services Needed			
6. Allergies			
7. DIET INSTRUCTION: <input type="checkbox"/> Regular <input type="checkbox"/> No added table salt <input type="checkbox"/> No concentrated sweets <input type="checkbox"/> Other			
8. STATUS OF THE FOLLOWING:			
AMBULATING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help <input type="checkbox"/> Bedridden	BATHING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	DRESSING <input type="checkbox"/> Independent <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs total help	



Yes NoTB Risk Assessment Form attached (required)A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free ofcontagion dated _____ .The above dated physical examination indicates this patient has the following physical or mental conditions that mightdanger the health of children or might prevent the patient from providing adequate care of children: _____ This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc. _____ SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER DATE PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)SUPERVISION OF A PHYSICIANNAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER IF NURSE IS SUPERVISED BY _____ PHYSICIAN, INDICATE PHYSICIAN'S NAME.(PLEASE USE STAMP, IF AVAILABLE) (PLEASE PRINT.) missouri department of health and senior servicessection for child care regulationMEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFFHave contact with children (infant through school-age) in care away from their own homes.be responsible for children's physical care and social development during day and/or nighttime hours.IDENTIFYING INFORMATION (To be completed by patient.)address (street, city, state, zip code)name and address of child care facility where employedMEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse orregistered nurse who is under the supervision of a licensed physician.)on _____ (date), i examined this patient. i certify that to the best of my knowledge, this patientis in good physical and emotional health and free of contagious disease.tb risk assessment form attached (required)a chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free ofcontagion dated _____ the above dated physical examination indicates this patient has the following physical or mental conditions that mightdanger the health of children or might prevent the patient from providing adequate care of children: _____ this patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc. _____ signature of physician or registered nurse underphysician's or nurse's name (please print.)supervision of a physiциanname and address of clinic, group practice, otherif nurse is supervised by physician, indicate physician's name.(please use stamp, if available)this form is to be kept on file at the child care facility missouri department of health and senior servicessection for child care regulationMEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFFHave contact with children (infant through school-age) in care away from their own homes.be responsible for children's physical care and social development during day and/or nighttime hours.IDENTIFYING INFORMATION (To be completed by patient.)address (street, city, state, zip code)name and address of child care facility where employedMEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse orregistered nurse who is under the supervision of a licensed physician.)on _____ (date), i examined this patient. I certify that to the best of my knowledge, this

patients in good physical and emotional health and free of contagious disease. i certify that to the best of my knowledge, the patient is in good physical and free of contagious disease.tb risk assessment form attached (weajop)chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free ofcontagion dated _____ .the above dated physical examination indicates this patient has the following physical or mental conditions that mightdanger the health of children or might prevent the patient from providing adequate care of children: _____ this patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc. _____

nurse's name (please print.)supervision of a physiannname and address of clinic, group practice, otherif nurse is supervised by physician, indicate physician's name.(please use stamp, if available)this form is to be kept on file at the child care facility Popular Articles How to Make a Quote: Free Quote Template How to Make a Quote: Free Quote Template USCIS Form I-551, Permanent Resident Card USCIS Form I-551, Permanent Resident Card Washington State Patrol Inspection Request Form Washington State Patrol Inspection Request Form Form MV-4ST, Vehicle Sales and Use Tax Return/Application for Registration Form MV-4ST, Vehicle Sales and Use Tax Return/Application for Registration USCIS Form I-797C, Notice of Action USCIS Form I-797C, Notice of Action Form REG 124, Application for Assigned Vehicle Identification Number Plate Form REG 124, Application for Assigned Vehicle Identification Number Plate Form VSD 190, Application for Vehicle Transaction(s) Form VSD 190, Application for Vehicle Transaction(s) Form DOS-1246, Security Guard Renewal Application Form DOS-1246, Security Guard Renewal Application Popular Articles How to Make a Quote: Free Quote Template How to Make a Quote: Free Quote Template USCIS Form I-551, Permanent Resident Card USCIS Form I-551, Permanent Resident Card Washington State Patrol Inspection Request Form Washington State Patrol Inspection Request Form Form MV-4ST, Vehicle Sales and Use Tax Return/Application for Registration Form MV-4ST, Vehicle Sales and Use Tax Return/Application for Registration USCIS Form I-797C, Notice of Action USCIS Form I-797C, Notice of Action Form REG 124, Application for Assigned Vehicle Identification Number Plate Form REG 124, Application for Assigned Vehicle Identification Number Plate Form VSD 190, Application for Vehicle Transaction(s) Form VSD 190, Application for Vehicle Transaction(s) Form DOS-1246, Security Guard Renewal Application Form DOS-1246, Security Guard Renewal Application Missouri Department of Health - Form BCCA Medical Examination Report for Caregivers and Staff Help Help Settings My Documents Log Out THIS FORM IS TO BE KEPT ON FILE AT THE CHILD CARE FACILITYMISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICESSECTION FOR CHILD CARE REGULATIONMEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFFPatient may: ✓ Have contact with children (infant through school-age) in care away from their own homes.✓ Be responsible for children's physical care and social development during day and/or nighttime hours.IDENTIFYING INFORMATION (To be completed by patient.)MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse orregistered nurse who is under the supervision of a licensed physician.)ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NUMBERNAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYEDOn _____ (date), I examined this patient.



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