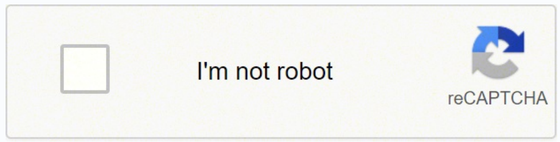
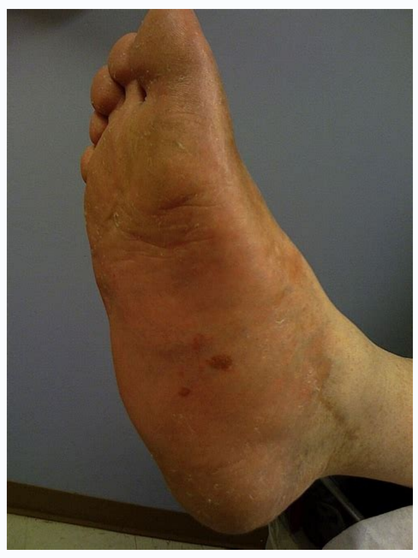


Next

Medical examination report for caregivers and staff



MEDICAL EVALUATION

NAME OF PATIENT			DOB
PRESENT ADDRESS			
CITY	STATE	ZIP	TELEPHONE

REASON FOR EVALUATION:
☐ Pre-Admission ☐ Annual ☐ Possible change in patient's condition ☐ 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: ☐ Regular ☐ No added table salt ☐ No concentrated sweets ☐ Other
8. STATUS OF THE FOLLOWING:

AMBULATING	BATHING	DRESSING
☐ Independent	☐ Independent	☐ Independent
☐ Needs supervision	☐ Needs supervision	☐ Needs supervision
☐ Needs assistance	☐ Needs assistance	☐ Needs assistance
☐ Needs total help	☐ Needs total help	☐ Needs total help
☐ Bedridden		

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 mightendanger 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 mightendanger 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 physicianname 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

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