IOWA CHILD CARE PROVIDER -- PHYSICAL EXAM REPORT [1]

Child Care Center Personnel • Child Development Home Providers

Name: Date:

Name of Child Care Business:

What child care activities do you do? Check all that apply. ☐ lift or carry children ☐ infants/toddler care ☐ preschool child care ☐ school-age child care ☐ first aid duties ☐ driving ☐ playground duty ☐ cleaning ☐ food preparation ☐ facility & ground maintenance ☐ office work ☐ I do child care in my home

CHILD CARE PROVIDER CONCERNS & NOTES: *I am concerned about the following health problems.*

Health Concern

- ☐ Allergies List:
- ☐ Breathing problems (asthma, emphysema)
- ☐ Dental problems or tooth related pain
- ☐ Diabetes
- ☐ Difficulty hearing
- ☐ Difficulty with vision
- ☐ Emotional or stress
- ☐ Heart or blood pressure problems
- ☐ Muscle, joint, or mobility problems Lifting restrictions

Health Concern

- ☐ Neurology problems (headaches, seizures, other)
- ☐ Skin problems (concerns about frequent handwashing)
- ☐ Smoking or alcohol use ☐ I want to stop smoking
- ☐ Stomach or bowel problems
- ☐ Susceptibility to infection or illness
- ☐ Tuberculosis or history of positive test
- ☐ I have a health problem that requires work modifications: Describe:

HEALTH CARE PROVIDER The physical exam should include functional assessment of vision and hearing, with a review / exam of systems. The exam should determine health conditions that pose a threat to the health, safety, or well-being of children in child care, and/or predispose the worker to occupational injury relating to the care of children in a child care setting.

Immune Status: The following list contains adolescent and adult immunizations.

Check if reviewed	**Immunization***	**Comments**: indicate if person is immune or if vaccine was given. An adult immunization card may be used in lieu of this table.
☐	Hepatitis A* ☐ Hepatitis B	
☐	HPV* Human Papillomavirus	
☐	Influenza (annual influenza season)	
☐	Meningococcal*	
☐	MMR Measles, Mumps, Rubella	
☐	Pneumococcal*	
☐	Polio (OPV or IPV)	
☐	Shingles* (Herpes Zoster)	
☐	Td/Tdap	
☐	Varicella (chicken pox)	

* Clinicians should use the Advisory Committee on Immunization Practices (ACIP) recommendations. www.cdc.gov

Communicable Disease Statement

Does the person have a known communicable disease that requires modification of job duties? ☐ NO ☐ YES If yes, list the job duty restrictions.

Does the person test positive or have a history of tuberculosis (TB)? ☐ NO ☐ YES Date of positive test _____
Has the person completed TB medical diagnosis and treatment? ☐ YES ☐ NO If the person needs medical treatment for TB, please contact the Iowa Department of Public Health, Tuberculosis Program 515-281-8636.

Health Status

Does the person have known health condition(s) that requires modification of job duties? ☐ NO ☐ YES List the job duty restrictions.

Health Care Provider Signature _____

Mailing Address _____ Telephone _____

Provider Type: ☐ MD ☐ DO ☐ PA ☐ ARNP

Name:

[1] This form meets the Iowa Administrative Code 441-109 Child Care Centers and IAC 441-110 Child Development Homes.
Child care center employees are required to have a physician-signed statement concerning health status. Child care center volunteers and substitutes are required to sign a statement of health status.
Child Development Home providers, substitute providers, and all provider household members that may be present when children are in the home are required to have a physician-signed statement of health status.

LICENSED CHILD CARE CENTER STATEMENT OF HEALTH

Substitutes and Volunteers

Name: Date:

Name of Child Care Business:

STATEMENT OF HEALTH

Have you had a physical exam within the last year? ☐YES ☐NO
Would you like assistance finding a health care provider or payment for a physical exam?[2] ☐ YES ☐ NO

IMMUNIZATION *

☐ **I DO NOT KNOW MY IMMUNIZATION HISTORY**

* An adult immunization card may be used in lieu of documenting in this table. For information about the adult immunizations call the Iowa Department of Public Health, Immunization Office Telephone: 800-831-6293

Please check if you have received the following immunizations

☐ Hepatitis A ☐ Hepatitis B
☐ HPV: Human Papillomavirus (adolescent & young adult females)
☐ Influenza (annual influenza season)
☐ Meningococcal
☐ MMR: Measles, Mumps, Rubella
☐ Pneumococcal
☐ Polio: (OPV or IPV)
☐ Shingles (Herpes Zoster)
☐ Td/Tdap tetanus, diphtheria, whooping cough
☐ Varicella (chicken pox)

Communicable Disease

To the best of your knowledge, do you have a communicable disease that requires modification of your job duties?
☐ NO ☐ YES (If yes, list your recommended job duty restrictions.)

Do you have a positive TB test or have a history of tuberculosis? ☐ NO ☐ YES Date of positive test _____
Have you completed medical diagnosis and treatment for TB? ☐ YES ☐ NO If you have questions or need medical treatment for TB, please contact the Iowa Department of Public Health, Tuberculosis Program 515-281-8636

Health Status

To the best of your knowledge, do you have health condition(s) that requires modification of your job duties?
☐ NO ☐ YES (Please list the job duty restrictions.)

Signature of Substitute / Volunteer _____ Date _____

Health Care Provider Signature _____

Mailing Address _____ Telephone _____

Provider Type: ☐ MD ☐ DO ☐ PA ☐ ARNP

Name: _____

[2] The Iowa Department of Public Health has women and men health programs, please call Healthy Families Line at 1-800-369-2229.