**Child Care Provider Health Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of essential job functions:

* Close contact with children
* Lifting, carrying children or equipment up to 40 pounds
* Food preparation
* Desk work
* Facility maintenance

To be completed by health provider:

Does this person have any other limiting condition(s) that would prevent him or her from working in a child care setting in the above activities:

* Yes
* No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Based upon my evaluation (select one)

* Applicant can perform the essential functions of the job without direct threat to the health and safety of self or others
* Applicant can perform the essential functions of the job without direct threat to the health and safety of self and others if the following restrictions can be accommodated:\_\_\_\_\_\_\_

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Unless otherwise required by the healthcare provider this health form must be completed every two years. Please indicate the frequency of this assessment:

* Yearly
* Every two years
* Other, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

Adapted from: Model Child Care Health Policies, Susan Aronson, MD (2002)

Healthy Child Care Colorado 2009