Child Care Licensing Unit
129 Pleasant Street
Concord, NH 03301

CHILD CARE PERSONNEL HEALTH FORM

NAME OF CHILD CARE PROGRAM: BSRC Wellness & Rec Center

NAME & ADDRESS OF EMPLOYEE: _____

_____

_____

MY SIGNATURE BELOW AUTHORIZES THE RELEASE OF THE FOLLOWING MEDICAL INFORMATION TO THE ABOVE NAMED CHILD CARE PROGRAM AND TO THE BUREAU OF CHILD CARE LICENSING.

_____ _____
EMPLOYEE SIGNATURE DATE SIGNED

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH PRACTITIONER.

TUBERCULIN TEST (REQUIRED FOR HIGH RISK INDIVIDUALS ONLY)

(IF YOU HAVE QUESTIONS ABOUT WHO MAY BE HIGH RISK, YOU MAY CONTACT THE TB PROGRAM FOR INFORMATION AT 1-800-852-3345, EXT. 4496 IN NH, OR OUTSIDE NH AT 603-271-4496)

TUBERCULIN SKIN TEST TYPE (MANTOUX RECOMMENDED): _____ DATE OF TEST _____

DATE OF INTERPRETATION _____ FINDINGS: _____(mm induration)
POSITIVE TUBERCULIN SKIN TEST MUST BE FOLLOWED UP BY A CHEST X-RAY AND REFERRAL TO A NH TB PROGRAM (271-4496)

DATE AND FINDINGS OF CHEST X-RAY: _____ _____

PHYSICIAN'S COMMENTS: _____

IMMUNIZATIONS: ITEMS 1 THROUGH 4 ARE RECOMMENDED, NOT REQUIRED BY LICENSING RULES

1. RUBELLA: DATE OF IMMUNIZATION: _____ OR DATE OF TITER: _____

2. MEASLES (RUBEOLA): DATE OF IMMUNIZATION(S): _____ _____ OR DATE OF TITER: _____

DATE OF DISEASE (MUST HAVE BEEN PHYSICIAN DIAGNOSED): _____

3. TETANUS/DIPHTHERIA/PERTUSSIS (TDAP—PREFERRED) OR TETANUS/DIPHTHERIA (TD): DATE OF IMMUNIZATION: _____

4. HEPATITIS B: DATE IMMUNIZATION SERIES COMPLETED: _____

PLEASE INDICATE BY CHECKING BELOW, ANY CURRENT OR PREVIOUS ILLNESS WHICH COULD IMPACT THE EXAMINEE'S ABILITY TO ADEQUATELY CARE FOR CHILDREN.

	YES	NO	UNKNOWN		YES	NO	UNKNOWN
TUBERCULOSIS OR OTHER PULMONARY PROBLEMS	☐	☐	☐	FAINTING AND DIZZY SPELLS	☐	☐	☐
HEART DISEASE	☐	☐	☐	EPILEPSY OR NEUROLOGICAL CONDITION	☐	☐	☐
DIABETES	☐	☐	☐	SERIOUS DEFECTS OF BONES & JOINTS	☐	☐	☐
OTHER CHRONIC DISEASE	☐	☐	☐	OTHER COMMUNICABLE DISEASE	☐	☐	☐
MENTAL OR EMOTIONAL DISTURBANCE	☐	☐	☐	ALCOHOL OR DRUG DEPENDENCY	☐	☐	☐

SPECIFICS REGARDING ANY OF THE ABOVE CONDITIONS:

PLEASE LIST ANY MEDICATION CURRENTLY PRESCRIBED, WHICH COULD EFFECT HIS/HER ABILITY TO CARE FOR CHILDREN:

_____

_____

IMPRESSION OF PRESENT STATE OF HEALTH:

_____

_____

☐ BECAUSE OF THE CONDITIONS NOTED ABOVE I DO NOT RECOMMEND THAT THE EXAMINEE BE EMPLOYED CARING FOR CHILDREN. (IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE SIDE OF FORM)

DATE OF EXAMINATION (IF DIFFERENT THAN THE DATE SIGNED BELOW): _____

BY SIGNING BELOW I HEREBY CERTIFY THAT THIS PATIENT HAS NO APPARENT HEALTH PROBLEMS THAT WOULD PROHIBIT HIS/HER EMPLOYMENT CARING FOR CHILDREN UNLESS THE BOX ABOVE IS CHECKED.

_____ _____
SIGNATURE OF LICENSED HEALTH PRACTITIONER **DATE SIGNED**

_____
PLEASE TYPE OR PRINT NAME AND ADDRESS OF LICENSED HEALTH PRACTITIONER