



# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS RECORD OF ADULT PHYSICAL HEALTH EXAMINATION

State Form 49970 (R / 11-06) / BCC 0020

BUREAU OF CHILD CARE  
DIVISION OF FAMILY RESOURCES

Name	Date of birth (month, day, year)
Address (number and street, city, state, and ZIP code)	

## MEDICAL HISTORY

I. List past hospitalizations / operations / accidents:

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II. Communicable diseases you have had:

<input type="checkbox"/> Measles	Month / year	<input type="checkbox"/> Scarlet Fever	Month / year	<input type="checkbox"/> Rubella (German Measles)	Month / year
<input type="checkbox"/> Chicken Pox	Month / year	<input type="checkbox"/> Mumps	Month / year	<input type="checkbox"/> Whooping Cough	Month / year
<input type="checkbox"/> Other:					Month / year

III. Conditions (Please explain if present):

Allergies:

Chronic health conditions:

Use of any drugs / medication:

Why?

## PHYSICAL EXAMINATION

I. Mantoux TB skin test *	Date (month, day, year)	Result (in mm)
Chest X-ray, if above skin test is positive?	Date (month, day, year)	Result

Other laboratory test as ordered by physician:

II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities (including sports)?

No  Yes

If Yes, what modifications of normal activities are necessary?

III. Have you prescribed any medications and / or special routines (such as diet) which should be included in planning this person's activities?

No  Yes

Explain:

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Date of exam (month, day, year)	Signature of physician / nurse practitioner
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\* Annual testing for tuberculosis is required.