MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

SAVE PRINT RESET

Patient may:
- ✓ Have 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.
- ✓ Need to lift children.

IDENTIFYING INFORMATION (To be completed by patient.)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )
NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED	

MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)

PHYSICAL EXAMINATION

On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. ☐ Yes ☐ No

TB CLEARANCE

(Check one.)

☐ 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 of contagion dated _____ .

LIMITATIONS

The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:

☐ None

☐ _____

RESTRICTIONS

This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.

☐ None

☐ _____

REMARKS

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)
NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE)		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.)
		TELEPHONE NUMBER ( )

THIS FORM IS TO BE KEPT ON FILE AT THE CHILD CARE FACILITY