



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION  
**MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF**

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.)**

<b>PHYSICAL EXAMINATION</b>	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. <input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>TB CLEARANCE</b>	(Check one.) <input type="checkbox"/> Negative tuberculin (TB) skin test results dated _____ <input type="checkbox"/> A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____
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<b>LIMITATIONS</b>	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: <input type="checkbox"/> None <input type="checkbox"/> _____
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<b>RESTRICTIONS</b>	This patient has the following restrictions, e.g. cannot lift children who weigh more than 20 pounds, etc. <input type="checkbox"/> None <input type="checkbox"/> _____
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**REMARKS**

**SIGNATURES**

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE 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 (    )	