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
- ☐ Driver of vehicles
- ☐ Desk work
- ☐ Facility maintenance

TO BE COMPLETED BY THE HEALTH CARE 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: _____

_____

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 others if the following restrictions can be accommodated:

_____

_____

Unless otherwise required by the health care 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