1008 South Second Street
Clearfield, PA 16830
(814) 765-2686
Fax: 765-6530
www.childaid.org

STAFF HEALTH APPRAISAL

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

NAME AND ADDRESS OF INDIVIDUAL EXAMINED

NAME OF EMPLOYER: Children's Aid Society	**EMPLOYER'S TELEPHONE NUMBER:** (814) 765-2686
EMPLOYER'S ADDRESS: 1008 South Second Street, Clearfield, PA 16830	

PURPOSE OF EXAMINATION

- ☐ INITIAL EMPLOYMENT
- ☐ BIENNIAL RE-EXAMINATION

TYPE OF ACTIVITY IN CAS (check all applicable)

- ☐ CARING FOR CHILDREN
- ☐ FOOD PREPARATION
- ☐ DESK WORK
- ☐ FACILITY MAINTENANCE
- ☐ HOME VISITING OR OTHER COMMUNITY ACTIVITIES
- ☐ LIFTING OF CHILDREN
- ☐ CLOSE INTERACTION WITH CHILDREN
- ☐ CLERICAL/OFFICE
- ☐ DRIVER OF VEHICLE(S)
- ☐ OTHER – DESCRIBE BELOW

THIS SECTION TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)

PART I

1. **DID YOU CONDUCT A PHYSCIAL EXAMINATION?** ☐ YES ☐ NO
   The physical examination should include a functional assessment of vision and hearing and a systems review looking for conditions that might affect performance of predispose this individual to occupational injury relating to the type of activities required by the job (see type of job listed above.) For child care staff: Conditionals also include frequent hand washing, the stress of caring for groups of children, ability to actively supervise children, and exposure to the common infections of childhood. Please take note that substance abuse should be considered in determining suitability to provide child care.
2. **DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES?** ☐ YES ☐ NO
   If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.
3. **BASED ON YOUR FINDINGS FOR #1 AND #2 ABOVE AND OTHER INFORMATION GATHERED DURING YOUR EXAMINATION, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE AND/OR DUTIES LISTED ABOVE.** ☐ YES ☐ NO

IF YOU ANSWERED "NO" TO QUESTION #3, please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of children or prohibit the individual from providing safe and adequate care to children. Please attach separate pages as needed.

PART II TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX METHOD OR THE IGRA BLOOD TEST

Please note: The child care facility regulations require tuberculosis testing by Mantoux skin test or the IGRA blood test at initial employment in a child care setting. Subsequent testing is not required unless directed by a physician, physician's assistant, CRNP, the Department of Health or a local health department.

TB TEST DATE:	**RESULTS:** ☐ POSITIVE ☐ NEGATIVE

IF SKIN TEST IS POSITIVE:	REPORT OF CHEST X-RAY (Please attach an official radiology report) Does this individual need chemoprophylaxis? ☐ YES ☐ NO

Please note: For the purposes of meeting the child care facility regulations, a person with a positive tuberculin skin test and a negative x-ray is not required to have further tuberculosis testing or x-rays, unless the person is exposed to an active case of tuberculosis or the person develops a productive cough which does not respond to medical treatment within 14 days.

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH APPRAISING		
PART III – Record of Immunizations- ***Children's Aid Society requires all employees receive Tdap vaccine once, regardless of when they last received a tetanus booster. Please indicate date of last Tdap vaccine.***	**YES**	**NO**
4. Are any other immunizations recommended for this employee to work with children and older adults? If yes, what immunizations are recommended?		
THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH APPRAISING		
PART IV – Physical Demands	**YES**	**NO**
5. Is this individual able to lift equipment weighing 30 lbs from waist to chest using proper technique?		
6. Is this individual able to lift supplies weighing 30 lbs from floor to waist using proper technique		
7. Is this individual able to push and pull filing drawers weighting 30 lbs using proper technique?		
8. Is this individual able to stand 4 hours a day, based on a 7 hour day?		
9. Is this individual able to sit for 7 hours per day, constant sitting?		
10. Is this individual able to move throughout general office settings and various private homes and public buildings?		
11. Is this individual able to control his/her body through motion for bending/squatting to pick up supplies?		
12. Is this individual able to use hands for fine motor skills and computer use?		
13. Does this individual have the visual acuity to pass the Snellen Chart test?		
14. Does this individual have the hearing acuity to pass the Whispered Voice test?		
15. Is this individual able to tolerate climate changes from 25 to 90 degrees while moving between buildings and supervising outdoor activities?		

DATE	SIGNATURE	TITLE
TELEPHONE NO.	PRINTED NAME	
ADDRESS		

PATIENT AUTHORIZATION

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. Unless prohibited by law, I authorize the physician or other person to disclose any knowledge or information pertaining to my health. I understand that any false or misleading statements may cause termination of my employment.

_____

Patient Signature

_____

Date