

**South Carolina Department of Social Services  
Child Care Regulatory Services**

**Staff Health Assessment**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

- Type of Activity in Child Care (Check all applicable)**
- Adult Member of Household   
  Food Preparation   
  Driver of Vehicle   
  Caring for children   
  Desk Work   
  Facility Maintenance

**THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH ASSESSMENT**

**PART I – MEDICAL HISTORY – Does this person have any of the following medical problems?**

	Yes	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		
History of epilepsy?		
Diabetes?		
Current drug or alcohol dependency?		
Disabling emotional disorder?		
Does this person have any special medical or mental problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children. If yes, explain on reverse of form.		
Speech disorder?		
Significant physical findings/chronic medical condition or physical impairment?		
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		

**PART II – AS SHOWN BY PHYSICAL EXAMINATION, DOES THE INDIVIDUAL HAVE:**

	Yes	No
At least 20/20 combined vision, corrected by glasses if needed?		
Normal hearing?		
Normal blood pressure?		

**PART III – COMMUNICABLE DISEASES – Does this person have a communicable disease which would prohibit him/her from working in a child care facility?**

Yes     No    If yes, please comment: \_\_\_\_\_

**Tuberculosis Certification** (if medically recommended or required by the Local Health Officer)

<b>TYPE OF TEST:</b>	<b>READING:</b>	<b>DATE:</b>

**Immunization Status**

Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV. Immunization status reviewed:  Yes     No

Comments: \_\_\_\_\_

Print Name & Address of Health Care Provider

Telephone Number

Signature of Health Care Provider

Date of Examination

**HEALTH ASSESSMENTS MUST BE OBTAINED AT LEAST EVERY FOUR (4) YEARS AFTER INITIAL ASSESSMENT AND SUBSEQUENTLY ACCORDING TO THE STATUTE.**