STAFF HEALTH EXAMINATION FORM

TO BE COMPLETED BY APPLICANT

PATIENT'S NAME:		BIRTHDATE:	

I authorize (health care provider's name) _____ to release my medical information to (center) _____ in connection with my job application.

I understand that the center will keep this information confidential.

PATIENT'S SIGNATURE:		DATE:	

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above-named patient is applying for employment at our child care center. New Jersey State regulations require a health care provider's statement indicating that he or she is in good health and poses no health risk to persons at the center. Such statement shall be based on a medical examination within the six months immediately preceding such person's working at the center.

A Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin, except that the staff member shall have a chest x-ray taken if he or she has had a previous positive Mantoux tuberculin test. The staff member shall submit to the center written documentation of the results of the test and x-ray.

If the Mantoux tuberculin test result is insignificant (zero to nine millimeters (mm) of induration), no further testing shall be required.

If the Mantoux tuberculin skin test result is significant (10 or more mm of induration), the individual shall have a chest x-ray taken. If the chest x-ray shows significant results, the staff member shall not come in contact with the children unless he or she submits to the center a written statement from a health care provider certifying that he or she poses no threat of tuberculosis contagion

DATE OF MANTOUX TEST:		RESULTS:	
DATE OF CHEST X-RAY (IF APPLICABLE):		RESULTS:	
DATE OF PHYSICAL EXAMINATION: (must be within 6 months immediately preceding hire date)		RESULTS:	

Is there any reason to preclude this patient from working with children?

☐ NO

☐ YES (please explain):

REMARKS:

I have examined the above-named patient and found him/her to be in good health and to pose no health risk to others at the child care center.

HEALTH CARE PROVIDER'S SIGNATURE:		DATE:	
HEALTH CARE PROVIDER'S NAME:			
HEALTH CARE PROVIDER'S OFFICE ADDRESS (PRINT OR STAMP):			