

**HEALTH SCREENING REPORT - FACILITY PERSONNEL**

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

**A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.**

FACILITY NAME FOOTSTEPS CHILD CARE INC.
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FACILITY ADDRESS 374 EL CAMINO REAL, BELMONT CA 94002
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PERSON'S NAME	AGE	
POSITION TITLE	TYPE OF FACILITY: <b>CHILD CARE</b>	WORK DAYS PER WEEK
		WORK HOURS PER DAY

DUTY STATEMENT

Moving, stretching, and being involved in activities with infants to middle school children. Ability to lift up to 40 lbs.

TYPES OF PERSONS SERVED (Check appropriate items)

- |  |                                  |   |   |
|--|----------------------------------|---|---|
| <input type="checkbox"/> Infants         | <input type="checkbox"/> Adults  | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Physically Handicapped |
| <input type="checkbox"/> Children        | <input type="checkbox"/> Elderly | <input type="checkbox"/> Mentally Disordered      | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Other (specify) |                                  |   |   |

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE

ADDRESS

DATE

**NOTE TO PHYSICIAN:** Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

PLEASE INCLUDE THE FOLLOWING INFORMATION AND ATTACH DOCUMENTATION SIGNED BY A PRACTITIONER:

DATE OF PERTUSSIS IMMUNIZATION:

DATE OF MEASLES IMMUNIZATION:

DATE OF LAST FLU SHOT:

DATE OF T.B. TEST

 POSITIVE NEGATIVE

ACTION TAKEN (IF POSITIVE)

PRINT NAME OF PHYSICIAN (OR PHYSICIAN'S STAMP)

HEALTH SCREENING BY: (ORIGINAL SIGNATURE)

TELEPHONE #

DATE