

## STAFF HEALTH REPORT – LICENSED CHILD CARE CENTERS

**Use of form:** This form is mandatory. When completed and on file, it meets the requirements of DCF 250.04(5)(e) and DCF 251.05(1)(L)1. of the Wisconsin Administrative Code. Failure to obtain a completed form for placement in the staff file may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The examining health professional will complete this form, sign Sections B and C and return the completed form to the individual for placement in the staff file. If the tuberculosis test is completed separately from the physical examination, each examining health professional will complete and sign the appropriate section and return the completed form to the individual for placement in the staff file. Both sections must be completed and on file to meet the licensing requirements.

**A. STAFF INFORMATION** FCC: provider, employee, substitute. GCC: persons who work directly with children except volunteers.

Name (Last, First, MI)	Position Title
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**B. TUBERCULOSIS TEST – MANTOUX Tuberculin Skin Test OR QuantiFERON Blood Assay for M. Tuberculosis**

Date of Test (mm/dd/yyyy)	Risk Classification <input type="checkbox"/> Low risk <input type="checkbox"/> Medium risk <input type="checkbox"/> Potential ongoing transmission	Millimeters of Induration <input type="checkbox"/> 5mm <input type="checkbox"/> 10 mm <input type="checkbox"/> 15mm
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Positive    Negative   What were the results of the TB test?

Positive    Negative   If the results of the TB test were positive, what were the results of the follow-up medical evaluation?

Yes    No   Was a chest X-ray completed?

<b>SIGNATURE</b> – MD, PA or Health Check Provider	Name – Examining Health Professional (Type or Print)
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Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)
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**C. PHYSICAL EXAMINATION**

Yes    No   I certify based upon my examination that this person appears free of symptoms of illness or communicable disease that may be transmitted through normal contact.

Yes    No   I certify based upon my examination that this person appears to be physically able to work with children.

**NOTE:** This individual will be in contact with children receiving child care services and may be responsible for the physical care and social development of young children during the hours child care is provided. Some lifting of young children may be required.

Comments:

<b>SIGNATURE</b> – MD, PA or Health Check Provider	Name – Examining Health Professional (Type or Print)
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Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)
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