MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

INSTRUCTIONS

This form is to be completed by the child care provider and a licensed physician.
Once complete, it should be kept on file at the child care facility for review during inspections.

The reason for this medical examination is that the patient may:

- Have contact with children (infant through school-age) in care away from their own homes.
- Be responsible for children's physical care and social development during day and/or nighttime hours.
- Need to lift children.

IDENTIFYING INFORMATION (TO BE COMPLETED BY PATIENT)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER
NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED	

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

MEDICAL REPORT (TO BE COMPLETED BY A LICENSED PHYSICIAN, ADVANCE PRACTICE NURSE, REGISTERED PROFESSIONAL NURSE, OR REGISTERED NURSE WHO IS UNDER THE SUPERVISION OF A LICENSED PHYSICIAN.)

PHYSICAL EXAMINATION	On the date of _________________, I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. ☐ Yes ☐ No
TB CLEARANCE	Check one of the following: ☐ TB Risk Assessment form attached ☐ Negative Tuberculin Skin Test attached ☐ A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated________________________.
LIMITATIONS	Unless noted in the remarks below, the above dated physical examination indicates this patient has no physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children.
RESTRICTIONS	Unless noted in the remarks below the above dated physical examination indicates this patient has no restrictions — e.g., cannot lift children who weigh more than 20 pounds, etc.
REMARKS	

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE)		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT)
		TELEPHONE NUMBER

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