MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

# MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

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 | |
| | |

**MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)**

| | |
|---|---|
| **PHYSICAL EXAMINATION** | On _____ (date), 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.)<br>☐ TB Risk Assessment Form attached (required)<br>☐ A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____ . |
| **LIMITATIONS** | The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:<br>☐ None<br>☐ _____ |
| **RESTRICTIONS** | This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.<br>☐ None<br>☐ _____ |

**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<br>( ) |

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

# Tuberculosis (TB) Risk Assessment Form

**Patient's Name:** _____ **Date of Birth:** _____ **Date:** _____
**Address:** _____ **Phone Number:** _____

**A. Please answer the following questions (Sections A & B to be completed by Patient):**

| | |
|---|---|
| Have you ever had a positive Mantoux tuberculin skin test (TST)? | ☐ Yes ☐ No |
| Have you ever been vaccinated with BCG? | ☐ Yes ☐ No |
| Have you ever had a positive Interferon Gamma Release Assay (IGRA) test? | ☐ Yes ☐ No |
| Have you ever been diagnosed with or treated for TB Disease? | ☐ Yes ☐ No |

**B. TB Risk Assessment**

| | |
|---|---|
| Have you ever had close contact with anyone who was sick with tuberculosis? | ☐ Yes ☐ No |
| Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.** | ☐ Yes ☐ No |
| Were you born in one of the countries listed below? **If yes, please list the country:** _____<br>What year did you arrive in the United States? _____ | ☐ Yes ☐ No |

| | | | | | | |
|---|---|---|---|---|---|---|
| Afghanistan | Cape Verde | Gabon | Kuwait | Myanmar | St. Vincent & | Tokelau |
| Algeria | Central African Rep. | Gambia | Kyrgyzstan | Namibia | The Grenadines | Tonga |
| Angola | Chad | Georgia | Lao PDR | Nauru | Sao Tome & Principe | Trinidad & Tobago |
| Anguilla | Chile | Ghana | Latvia | Nepal | Saudi Arabia | Tunisia |
| Argentina | China | Greenland | Lesotho | Nicaragua | Senegal | Turkey |
| Armenia | Colombia | Guatemala | Liberia | Niger | Serbia | Turkmenistan |
| Azerbaijan | Comoros | Guinea | Libyan Arab Jamihirya | Nigeria | Seychelles Sierra | Turks & Caicos |
| Bahrain | Congo | Guinea-Bissau | Lithuania | Niue | Leone | Islands |
| Bangladesh | Congo DR | Guam | Macedonia-TFYR | Northern Mariana | Singapore | Tuvalu |
| Belarus | Cote d'Ivoire | Guyana | Madagascar | Islands | Solomon Islands | Uganda |
| Belize | Croatia | Haiti | Malawi | Pakistan | Somalia | Ukraine |
| Benin | Djibouti | Honduras | Malaysia | Palau | South Africa | Uruguay |
| Bhutan | Dominica | Hungary | Maldives | Panama | Sri Lanka | Uzbekistan |
| Bolivia | Dominican Republic | India | Mali | Papua New Guinea | Sudan | Vanuatu |
| Bosnia & Herzegovina | Ecuador | Indonesia | Marshall Islands | Paraguay | Sudan - South | Venezuela |
| Botswana | Egypt | Iran | Mauritania | Peru | Suriname | Viet Nam |
| Brazil | El Salvador | Iraq | Mauritius | Philippines | Syrian Arab Republic | Wallis & Futuna |
| Brunei Darussalam | Equatorial Guinea | Japan | Mexico | Poland | Swaziland | Islands |
| Bulgaria | Eritrea | Kazakhstan | Micronesia | Portugal | Tajikistan | Yemen |
| Burkina Faso | Estonia | Kenya | Moldova-Rep. | Qatar | Tanzania-UR | Zambia |
| Burundi | Ethiopia | Kiribati | Mongolia | Romania | Thailand | Zimbabwe |
| Cambodia | Fiji | Korea-DPR | Morocco | Russian Federation | Timor-Leste | |
| Cameroon | French Polynesia | Korea-Republic | Mozambique | Rwanda | Togo | |

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://www.who.int/topics/tuberculosis/en/.

| | |
|---|---|
| Have you ever had an abnormal chest x-ray suggestive of TB? | ☐ Yes ☐ No ☐ No Response |
| Are you HIV positive? | ☐ Yes ☐ No ☐ No Response |
| Are you an organ transplant recipient or donor? | ☐ Yes ☐ No ☐ No Response |
| Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)? | ☐ Yes ☐ No ☐ No Response |
| Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)? | ☐ Yes ☐ No ☐ No Response |
| Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)? | ☐ Yes ☐ No ☐ No Response |
| Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats? | ☐ Yes ☐ No ☐ No Response |
| Are you coughing up blood or phlegm? | ☐ Yes ☐ No ☐ No Response |

**I hereby certify** that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ Patient Signature (Required)

_____ Date: