



HEALTH CARE PROGRAM FOR CHILD CARE RECORD OF ADULT PHYSICAL HEALTH EXAMINATION

State Form 49970 (R6 / 7-19)

**FAMILY AND SOCIAL SERVICES
ADMINISTRATION**
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name	Date of birth (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)	

MEDICAL HISTORY

I. List past hospitalizations / operations / accidents:

II. Vaccines / immunities:

<input type="checkbox"/> Measles	Month / year	<input type="checkbox"/> Mumps	Month / year	<input type="checkbox"/> Rubella (German Measles)	Month / year
<input type="checkbox"/> Chicken Pox	Month / year	<input type="checkbox"/> Scarlet Fever	Month / year	<input type="checkbox"/> Whooping Cough	Month / year
<input type="checkbox"/> Other:	Month / year	<input type="checkbox"/> Tdap Booster	Month / year		

III. Conditions (*Please explain if present*):

Allergies:

Chronic health conditions:

Use of any drugs / medication:

Why?

PHYSICAL EXAMINATION

I. Mantoux TB skin test or ISDH approved screen *	Date (<i>month, day, year</i>)	Result (<i>in mm</i>)
Chest X-ray, if above screen is positive?	Date (<i>month, day, year</i>)	Result
Other laboratory test as ordered by physician:		
II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities (<i>including sports</i>)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, what modifications of normal activities are necessary?		
III. Have you prescribed any medications and / or special routines (<i>such as diet</i>) which should be included in planning this person's activities?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:		
<hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/>		

* Annual ISDH approved screening for tuberculosis is required.

Date of examination (<i>month, day, year</i>)	Signature of physician / nurse practitioner / physician assistant
Telephone number ()	Printed name of physician / nurse practitioner / physician assistant