



(215) 348 2660

Windmill Day School & Camp

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WINDMILL STAFF HEALTH APPRAISAL

NAME OF PERSON EXAMINED

DID YOU CONDUCT A PHYSICAL EXAMINATION? (CIRCLE)

YES

NO

(THE PHYSICAL EXAMINATION SHOULD INCLUDE A FUNCTIONAL ASSESSMENT OF VISION, HEARING, AND A SYSTEMS REVIEW LOOKING FOR CONDITIONS THAT MIGHT AFFECT PERFORMANCE OR PREDISPOSE THE INDIVIDUAL TO OCCUPATIONAL INJURY RELATED TO LIFTING, FREQUENT HAND WASHING, THE STRESS OF CARING FOR GROUPS OF CHILDREN, DRIVING VEHICLES, FOOD PREPARATION, FACILITY MAINTENANCE, AND EXPOSURE TO THE COMMON INFECTIONS OF CHILDHOOD.)

DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES? (CIRCLE)

YES

NO

(IF YES, ATTACH SEPARATE SHEETS TO DESCRIBE THE CONDITION AND THE RISK IT MIGHT POSE TO OTHERS EXPOSED TO THIS INDIVIDUAL)

PLEASE LIST ANY INFORMATION REGARDING THIS INDIVIDUAL'S MEDICAL CONDITION THAT MIGHT THREATEN THE HEALTH OF CHILDREN OR PROHIBIT THE INDIVIDUAL FROM PROVIDING ADEQUATE CARE TO CHILDREN.

IN YOUR ASSESSMENT, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE? (CIRCLE)

YES

NO

(IF "NO" PLEASE EXPLAIN YOUR ANSWER ON A SEPARATE SHEET)

TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX METHOD

DATE TEST APPLIED

DATE TEST READ

PHYSICIAN'S
INTERPRETATION
OF TUBERCULIN TEST
RESULTS

DATE INTERPRETATION
MADE

PLEASE CIRCLE ONE:

POSITIVE

NEGATIVE

IF SKIN TEST POSITIVE:

REPORT OF CHEST X-RAY (ATTACH A COPY OF
REPORT)

DOES THIS INDIVIDUAL NEED CHEMOPROPHYLAXIS?
PLEASE CIRCLE: YES NO

DATE: _____ SIGNATURE: _____ MD / DO / CRNP

PRINTED NAME: _____ PHONE NUMBER: _____

ADDRESS: _____