

Annual Health Examination

<i>Last</i>	<i>First</i>	<i>Gender</i>	<i>DOB</i>	<i>Date of Exam</i>
<hr/>				
<i>Street</i>	<i>Apt</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

	Yes	No	Remarks
Hypertension			
Heart Disease			
Diabetes			
Seizure Disorder			
Chronic Lung Disease			
Mental Illness			
Substance Abuse			
Allergies			
Asthma			
Hepatitis			
Other (specify)			

PPD	Date Planted	Date Read	Results
Chest X-ray	Date	Results Normal/Abnormal	
Measles	Date		
Mumps	Date		
Rubella Titer and/or Vaccine	Date	Results Negative/Positive	Titer Value
Hepatitis B <i>If declined, please indicate</i>	Date	Date	Date
Tetanus <i>required every 10 years</i>	Date		
Diphtheria	Date		
Pertussis	Date		
Varicella <i>If declined, please indicate</i>	Date		
Influenza <i>If declined, please indicate</i>	Date		

	Yes	No	Remark
Does this individual present with any condition that would preclude his/her ability to work with children?			
Is this individual free from communicable diseases that would preclude him/her from working with children?			

Provider Information

<i>Print Last</i>	<i>First</i>	<i>License #</i>	<i>Phone</i>
<hr/>			
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
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<i>Provider Signature</i>		<i>Date</i>	