STAFF HEALTH REPORT – LICENSED CHILD CARE CENTERS

Use of form: This form is mandatory. When completed and on file, it meets the requirements of DCF 250.04(5)(e) and DCF 251.05(1)(L)1. of the Wisconsin Administrative Code. Failure to obtain a completed form for placement in the staff file may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The examining health professional will complete this form, sign Sections B and C and return the completed form to the individual for placement in the staff file. If the tuberculosis test is completed separately from the physical examination, each examining health professional will complete and sign the appropriate section and return the completed form to the individual for placement in the staff file. Both sections must be completed and on file to meet the licensing requirements.

A. STAFF INFORMATION FCC: provider, employee, substitute. GCC: persons who work directly with children except volunteers.

Name (Last, First, MI)	Position Title

B. TUBERCULOSIS TEST – MANTOUX Tuberculin Skin Test **OR** QuantiFERON Blood Assay for M. Tuberculosis

Date of Test (mm/dd/yyyy)	Risk Classification	Millimeters of Induration
	☐ Low risk ☐ Medium risk ☐ Potential ongoing transmission	☐ 5mm ☐ 10 mm ☐ 15mm

☐ Positive ☐ Negative What were the results of the TB test?

☐ Positive ☐ Negative If the results of the TB test were positive, what were the results of the follow-up medical evaluation?

☐ Yes ☐ No Was a chest X-ray completed?

SIGNATURE – MD, PA or Health Check Provider	Name – Examining Health Professional (Type or Print)
Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)

C. PHYSICAL EXAMINATION

☐ Yes ☐ No I certify based upon my examination that this person appears free of symptoms of illness or communicable disease that may be transmitted through normal contact.

☐ Yes ☐ No I certify based upon my examination that this person appears to be physically able to work with children.

NOTE: This individual will be in contact with children receiving child care services and may be responsible for the physical care and social development of young children during the hours child care is provided. Some lifting of young children may be required.

Comments:

SIGNATURE – MD, PA or Health Check Provider	Name – Examining Health Professional (Type or Print)
Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)