

**STATEMENT OF HEALTH OF PROVIDERS/ASSISTANT/STAFF MEMBERS**

Name: Sex: Male Female

Date of Birth: Telephone No:

Address: I have examined the above-named person and certify that he/she is:

- Free from disease in communicable form.

- Appears to be in satisfactory physical and mental health condition to care for residents at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of residential care facility for children)

In addition to a general physical health examination, the following tests have been done:

Blood Pressure\_\_\_\_\_\_ Blood Test\_\_\_\_\_\_\_

Urine Test\_\_\_\_\_\_\_\_ Stool Test \_\_\_\_\_\_\_\_

Chest X-Ray \_\_\_\_\_\_\_ Hepatitis\_\_\_\_\_\_\_\_\_\_

Remarks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Signature of Physician/ Nurse Practitioner) (Date of Examination)