South Carolina Department of Social Services
Child Care Licensing

Staff Health Assessment

NAME: _____DOB: _____

Type of Activity in Child Care *(Check all applicable)* ☐ Caring for children ☐ Desk Work
☐ Adult Member of Household ☐ Food Preparation ☐ Driver of Vehicle ☐ Facility Maintenance

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER WHO DOES HEALTH ASSESSMENTS

PART I – MEDICAL HISTORY – Does this person have any of the following medical problems?

	Yes	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		
History of epilepsy?		
Diabetes?		
Current drug or alcohol dependency?		
Disabling emotional disorder?		
Does this person have any special medical or mental problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children? If yes, explain on reverse of form.		
Speech disorder?		
Significant physical findings/chronic medical condition or physical impairment?		
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		

PART II – AS SHOWN BY PHYSICAL EXAMINATION, DOES THE INDIVIDUAL HAVE:

	Yes	No
At least 20/20 combined vision, corrected by glasses if needed?		
Normal hearing?		
Normal blood pressure?		
Date of Examination _____		

PART III – COMMUNICABLE DISEASES – Does this person have a communicable disease which would prohibit him/her from working in a child care facility?

☐ Yes ☐ No If yes, please comment: _____

_____

Tuberculosis Certification

Must be completed within 12 months prior to employment. TB Certification must be documented on the DHEC 1420, School Employee Certificate of Evaluation of TB according to SC DHEC Regulation 61-22
DHEC 1420 can be obtained at SCDHEC.gov

Immunization Status

Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV, and one-time adult dose of TDAP. Immunization status reviewed: ☐ Yes ☐ No

Comments: _____

_____

_____
Print Name & Address of Health Care Provider Telephone Number

_____
Signature of Health Care Provider Date Signed

HEALTH ASSESSMENTS MUST BE OBTAINED AT LEAST EVERY FOUR (4) YEARS AFTER INITIAL ASSESSMENT