RESULT OF TUBERCULIN TEST
CHILD DAY CARE CENTER & GROUP DAY CARE HOME PERSONNEL
(REQUIRED AT TIME OF EMPLOYMENT ONLY)

NAME OF PERSON: _____DATE OF BIRTH_____

ADDRESS: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

Results of: Tuberculin skin test ☐ Positive ☐ Negative
Or
Chest x-ray ☐ Positive ☐ Negative

Date Administered: _____Date Results Read: _____

Signature of Physician*****:_____

Address: _____ Phone Number: _____

City/Town: _____ State: _____Zip: _____

***This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.**

STATEMENT OF HEALTH STATUS
CHILD DAY CARE CENTER & GROUP DAY CARE HOME PERSONNEL
(REQUIRED EVERY TWO YEARS)

NAME OF PERSON: _____DATE OF BIRTH_____

ADDRESS: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

This statement is to certify that I examined the above named person and found him/her to be in good health and free from medical or emotional illness or disorder that would currently pose a risk to children in care or interfere with effective functioning as an employee of a child day care facility.

Signature of Physician*****: _____Date ____/____/____

Address: _____

City/Town: _____ State: _____ Zip: _____

***This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.**