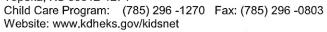
CCL. 009 Rev. 7/2016

Test read by \_

## Kansas Department of Health and Environment

Bureau of Family Health 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274





Date (MM/DD/YYYY)

## **CERTIFICATE OF HEALTH ASSESSMENT**

Street Address	City	Zip Code	Telephone Number
Name of office/clinic (Please Print):			
Authorizing Signature	Date	Authorized Signature	Date
Does <u>not</u> have evidence of a medical condition or mental lness that would interfere with typical child care duties listed bove.*		☐ Does have evidence of a medical condition or mental illness that would interfere with typical child care duties listed above.*	
have reviewed the above information, conducted an examination and any required tests. The above patient:		I have reviewed the above information, conducted an examination and any required tests. The above patient:	
TO BE COMPL	ETED BY A PERSON AUTHO	RIZED TO PERFORM HEALTH	ASSESSMENTS:
Provider/Staff Signature			
knowledge and belief. I hereby a	ains no willful misrepresentati uthorize the Kansas Departm rtment may contact others, se	ent of Health and Environment eek verification of any and all int	true and complete to the best of my to contact the persons listed on this ormation on this form. I understand
<ul> <li>CHILD CARE DAY DUTIES MA'</li> <li>Lifting and carrying childrer</li> <li>Close contact with children</li> <li>Driver of vehicle</li> </ul>	<ul><li>Stooping</li><li>Facility r</li><li>Food pre</li></ul>	maintenance • Reco eparation	of stairs (up and down) ordkeeping
<ul> <li>☐ Use of any durable medical equ</li> <li>☐ List any other medical condition</li> <li>☐ List any medications that would</li> </ul>	that would interfere with child	care duties:	
<ul> <li>□ Debilitating Headaches/Migrain</li> <li>□ Hearing or Vision</li> <li>□ Convulsions</li> </ul>	<ul><li>□ Diabetes</li><li>□ Liver Disease</li></ul>	<ul><li>☐ Active Substance Abuse</li><li>☐ Arthritis</li><li>☐ Lung Disease</li></ul>	
Check below any chronic illness(es	3	ay interfere with child care duties	
Name of Provider/Staff (First)	(Middle)	(Last)	e of Birth(MM/DD/YYYY)
TO BE COMPLETED BY PROVID			
Street Address	City	Zip Code	County
Name of the facility (exactly a	-		License #
CHILD CARE FACILITY:   Lice	censed or Group Day Care Hom	ne	chool/Head Start
(PA) may complete the health assess			

Licensed Physician/Nurse Signature or Health Department