

**PART A
 INDIVIDUAL INFORMATION**

Name		Birthdate
Street Address	City	Telephone
Name and Address of Facility for Whom You Work (If other than own home)		
Name of Facility	Street Address	
City	State	Zip Code

INDIVIDUAL HEALTH HISTORY

MEDICATIONS	List the Medications you are taking
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Are you being treated for/or have you ever been treated for:
 Drug Addiction: Yes No Alcoholism: Yes No Mental Illness: Yes No

In general, my mental and physical health is:

Please list the name of your physician, mental health practitioner, or drug and alcohol counselor. You are giving DHHS permission to contact the people listed below. All information is confidential

1.	Dr. Name	Address	City	State	Zip	Phone
2.	Dr. Name	Address	City	State	Zip	Phone
3.	Dr. Name	Address	City	State	Zip	Phone
4.	Dr. Name	Address	City	State	Zip	Phone

Signature of Individual SIGN HERE	Date
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PART B - HEALTH EXAMINATION
This section is to be completed by the Medical Practitioner

Blood Pressure	Urinalysis	Albumin_____	Sugar_____
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Is individual under treatment for Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does individual have any Communicable Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
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NOTE TO PHYSICIAN: This person will be caring for children. If individual is on medication, has a blood pressure higher than 160/95, or the above tests read positive or "YES," will this affect the individuals ability to care for children?
 Yes No

Comments:

Must be signed by Physician, Physician's Assistant or RN SIGN HERE	Date
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