

CHILD CARE STAFF HEALTH ASSESSMENT

(55 Pa. Code §§3270.151, 3280.151 and 3290.151)

NAME OF PERSON EXAMINED (Please print)	REASON FOR EXAMINATION <input type="checkbox"/> Initial employment in child care <input type="checkbox"/> Biennial re-examination
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THIS SECTION TO BE COMPLETED BY EMPLOYER

This physical examination is for the purpose of employment in a child care facility. The types of activities this individual will be doing are as follows (please check all that apply):

<input type="checkbox"/> Lifting, carrying children	<input type="checkbox"/> Desk work	<input type="checkbox"/> Other – describe below:
<input type="checkbox"/> Close interaction with children	<input type="checkbox"/> Driver of vehicle(s)	
<input type="checkbox"/> Food preparation	<input type="checkbox"/> Facility maintenance	

THIS SECTION TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)

1. DID YOU CONDUCT A PHYSICAL EXAMINATION? YES NO

The physical examination should include a functional assessment of vision and hearing and a systems review looking for conditions that might affect performance or predispose this individual to occupational injury relating to the type of activities required by the job (see type of job listed above.) Conditionals also include frequent hand washing, the stress of caring for groups of children, ability to actively supervise children, and exposure to the common infections of childhood. Please take note that substance abuse should be considered in determining suitability to provide child care.

2. DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES? YES NO

If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.

3. BASED ON YOUR FINDINGS FOR #1 AND #2 ABOVE AND OTHER INFORMATION GATHERED DURING YOUR EXAMINATION, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE? YES NO

IF YOU ANSWERED "NO" TO QUESTION #3, please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of children or prohibit the individual from providing safe and adequate care to children. Please attach separate pages as needed.

DATE	SIGNATURE	TITLE
TELEPHONE NO.	PRINTED NAME	
ADDRESS		

TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX OR INTERFERONGAMMA RELEASE ASSAY BLOOD TEST METHOD

Please note: The child care facility regulations require tuberculosis testing by Mantoux method or the interferongamma release assay (IGRA) blood test at initial employment in a child care setting. Subsequent testing is not required unless directed by a physician, physician's assistant, CRNP, the Department of Health or a local health department.

MANTOUX TEST DATE:	RESULTS: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
IF SKIN TEST IS POSITIVE:	REPORT OF CHEST X-RAY (Please attach an official radiology report)
	DOES THIS INDIVIDUAL NEED CHEMOPROPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO

Please note: For the purposes of meeting the child care facility regulations, a person with a positive tuberculin skin test or blood test and a negative x-ray is not required to have further tuberculosis testing or x-rays, unless the person is exposed to an active case of tuberculosis or the person develops a productive cough which does not respond to medical treatment within 14 days.

APPLICATION: National Sex Offender Registry Verification

The following individuals must complete the National Sex Offender Registry verification application:

- Any individual 18 years or older residing in the child care setting where child care is occurring.
- Any individual working for a Regulated Child Care Provider.
- Any individual with an ownership interest (corporate or non-corporate) in a Regulated Child Care Provider and who participates in the organization and management of the operation.
- Any volunteer of a child care provider, group day-care home or family child care home.

Type or print clearly in ink. Fill in all necessary fields on the application. Once completed, use one of the following three options to submit the application for processing:

1. Mail to the Clearance Verification Unit, ChildLine at the following address: Department of Human Services PO Box 8170 Harrisburg, PA 17105-8170; **OR**
2. Scan the completed application and email to: **RA-PWNSOR@pa.gov** In the subject line list 'NSOR Verification Applicant Last Name (i.e., Smith); **OR**
3. Hand deliver to the Clearance Verification Unit lobby located at: 5 Magnolia Drive, Harrisburg, PA 17110 (Hillcrest Building number 53). Free parking is available in Lot C.

- Processing time is fourteen days from the date the application is received.
- Retain a copy of the completed application for your record. You may need a copy as proof of your submission for your employer.
- There is no fee for the National Sex Offender Registry verification letter.
- Refer all questions to the Clearance Verification Unit at 877-371-5422.

Purpose of the National Sex Offender Registry Verification (Check one box only)

- Individual 18 years or older residing in the facility where child care is occurring.
- Individual working for a Regulated Child Care Provider.
- Individual with an ownership interest (corporate or non-corporate) in a Regulated Child Care Provider and who participates in the organization and management of the operation.
- Volunteer of a child-care provider, group-daycare home or family child care home.

Applicant Demographic Information (All fields required)

Full Name (Last, First, Middle Initial): _____

Social Security Number (XXX-XX-XXXX): _____

Date of Birth (MM/DD/YYYY): _____

Daytime Phone Number (XXX-XXX-XXXX): _____

Home Mailing Address: _____

_____ **Include full street address, (Apt # or PO Box if applicable),**

_____ **City, State and Zip Code**

E-mail Address: _____

I affirm the above information is accurate and complete to the best of my knowledge and belief, and submitted as true and correct under penalty of law per Section 4904 of the Pennsylvania Crimes Code.

Signature: _____

Date: _____



Child Care Employment Verification Form

Employee Section – (provide information on your previous employer)

Employee's Name: _____ Position Applied for: _____

Previous Company Name: _____

Supervisor Name: _____ Title: _____

Previous Company Address: _____

Phone Number: _____ Fax Number: _____

I hereby authorize you to provide information regarding my job performance, length of employment, and character to Wonderspring.

Employee Signature: _____ Date: _____

Previous Employer Section – (provide employment dates, hours, responsibilities, and optional comments)

Dates of Employment: _____

Hours Worked per Week: _____

Position/Title of Employee: _____

Duties and Responsibilities: _____

Additional Comments: _____

Verifier's* Signature: _____ Date: _____

Verifier's Title: _____ Contact number (if different from above: _____
*person recording information

For Office Use Only – Program Director, Center Director or HR to Complete

Total Hours per Week _____ x 4.33 weeks per month = _____

Total Hours per Month _____ x _____ # of months worked = _____

Total time worked _____ ÷ 1250 (1 year) = _____ years of experience

**PA regulations state that 1250 clock hours = 1 year of experience*