HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
RECORD OF ADULT PHYSICAL HEALTH EXAMINATION
GROUP HOMES / INSTITUTIONS

State Form 49970 (R5 / 2-15)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
402 W. Washington St., Room W361
Indianapolis, IN 46204

Name	Date of birth (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)	

MEDICAL HISTORY

I. List past hospitalizations / operations / accidents:

II. Communicable diseases you have had:

☐ Measles	Month / year	☐ Scarlet Fever	Month / year	☐ Rubella (German Measles)	Month / year
☐ Chicken Pox	Month / year	☐ Mumps	Month / year	☐ Whooping Cough	Month / year
☐ Other:			Month / year	☐ Tdap Booster	Month / year

III. Conditions (*Please explain if present*):

Allergies:

Chronic health conditions:

Use of any drugs / medication:

Why?

PHYSICAL EXAMINATION

I. Mantoux TB skin test or ISDH approved screen *	Date (*month, day, year*)	Result (*in mm*)
Chest X-ray, if above screen is positive?	Date (*month, day, year*)	Result

Other laboratory test as ordered by physician:

II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No

If Yes, what modifications of normal activities are necessary?

III. Have you prescribed any medications and / or special routines (*such as diet*) which should be included in planning this person's activities?

☐ Yes ☐ No

Explain:

Date of exam (*month, day, year*)	Signature of physician / nurse practitioner	Printed name of physician / nurse practitioner	Telephone number ( )

* Annual ISDH approved screening for tuberculosis is required.