

# PHYSICIAN EVALUATION FORM

PROGRAM: \_\_\_\_\_

PHONE: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

DATE: \_\_\_\_\_

## TO BE COMPLETED BY CHILD CARE PROVIDER

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Has  Has Not been excluded from our child care setting.

The following signs and/or symptoms have been noted:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vomiting                                       | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Rash               |
| <input type="checkbox"/> Jaundice                                       | <input type="checkbox"/> Bloody diarrhea | <input type="checkbox"/> Skin lesions       |
| <input type="checkbox"/> Eye drainage                                   | <input type="checkbox"/> Light stool     | <input type="checkbox"/> Mouth sores        |
| <input type="checkbox"/> Respiratory signs                              | <input type="checkbox"/> Dark urine      | <input type="checkbox"/> Fever, temp. _____ |
| <input type="checkbox"/> Cough/wheezing                                 |  |   |
| <input type="checkbox"/> Other concerns in our daily health observation |  |   |

For your information, \_\_\_\_\_ cases of \_\_\_\_\_  
have recently been reported in others attending our program.

HEALTH CARE PROVIDER,  
PLEASE EVALUATE THIS CHILD AND COMPLETE THE REMAINDER OF THIS FORM.

## DIAGNOSIS

Diagnosis \_\_\_\_\_  Not Communicable  Communicable

## TREATMENT/MEDICATION

Medication \_\_\_\_\_  Dosage \_\_\_\_\_  
 Other \_\_\_\_\_

## RETURN TO CHILDCARE

May return to child care  
 Exclude until

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTE!** If a reportable communicable disease is diagnosed, the public health department may have additional restrictions or requirements.

Parent/guardian must return this completed for to the child care program when the child returns.