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|  | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN'S DIVISION  **MEDICAL EXAMINATION REPORT FOR RESIDENTIAL TREATMENT AGENCY FOR**  **CHILDREN AND YOUTH PROVIDER/STAFF** | | | | | | | | | | | | | |
| **I. IDENTIFYING INFORMATION (TO BE COMPLETED BY PATIENT)** | | | | | | | | | | | | | | | |
| NAME | | | | | | | | | | | | | BIRTHDATE | | |
| ADDRESS(STREET, CITY, STATE, ZIP CODE) | | | | | | | | | | | | | TELEPHONE NUMBER  (   ) | | |
| NAME OF RESIDENTIAL TREATMENT AGENCY WHERE EMPLOYED | | | | | | | | | | | | | | | |
| **II. TO BE COMPLETED BY A LICENSED PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A LICENSED PHYSICIAN** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | YES | NO |
| This individual will be in contact with children, ages | | | | | |  | through | |  | receiving child care outside their own | | | |  |  |
| homes. S/he may be responsible for the physical care and social development of young children during daytime and/or nighttime hours. Some lifting of young children may be required. | | | | | | | | | | | | | |
| On |  | | (date) I examined this patient and certify -- | | | | | | | | | | |  |  |
|  | | | | | | | | | | | | | |
| 1. That s/he is in good physical and emotional health and free of communicable disease.   If recommended by a physician, a TB test, chest x-ray, and/or a follow up examination was | | | | | | | | | | | | | |  |  |
| completed on | | | |  |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| B. To the best of my knowledge s/he is free of impairment due to the use of medication; | | | | | | | | | | | | | |  |  |
| C. To the best of my knowledge s/he is free of current drug or alcohol dependency; and | | | | | | | | | | | | | |  |  |
| Does patient have any physical or mental conditions which might endanger the health of children or that might prevent him/her from providing adequate care for children? If yes, explain below. | | | | | | | | | | | | | |  |  |
| Are there any restrictions on children’s ages, numbers of children or hours of care? If yes, explain below. | | | | | | | | | | | | | |  |  |
| Remarks/Restrictions, if any: | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | |  | | | | |
| Signature of Physician or Registered Nurse under the Supervision of a Physician | | | | | | | | Date | | | Physician’s or Nurse’s Name (Please Print) | | | | |
|  | | | | | | | |  | | | | | | | |
| Name of Clinic, Group Practice, Other | | | | | | | | If Nurse is Supervised by a Physician, indicate Physician’s Name | | | | | | | |
|  | | | | | | | | | | | |  | | | |
| Address (Street, City, State and Zip Code) | | | | | | | | | | | | Telephone Number | | | |