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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN'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 -- |  |  |
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| 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 |