

# OPERATION Breakthrough

## VOLUNTEER APPLICATION

Please circle one: Ms. Mrs. Mr. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

(City)

(State)

(Zip Code)

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact: \_\_\_\_\_

(Name)

(Phone#)

How did you hear about Operation Breakthrough's Volunteer Program?

Have you lived in a different state in the last 5 years? Yes No (If yes: List States \_\_\_\_\_)

Reason for Volunteering: \_\_\_\_\_

Number of Required Hours \_\_\_\_\_ Completed by (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

*All volunteer hours are recorded and saved for future reference.*

*By signing below you understand the requirements of the volunteer program that you are applying for and commit to following them, and communicating with the volunteer department if something were to come up causing you to not keep your full volunteer commitment. You accept responsibility for all of your actions while at the center, traveling to and/or from the center, or engaged in any activity held by or for Operation Breakthrough. You understand that Operation Breakthrough cannot be held liable for any loss, personal injury, accident, misfortune or damage to yourself or your property.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (if under 18)

### For Internal Office Use Only

\_\_\_\_ Volunteer Application \_\_\_\_ BC \_\_\_\_ EL \_\_\_\_ FP Orientation Date: \_\_\_\_\_

\_\_\_\_ Volunteer Agreement \_\_\_\_ PS \_\_\_\_ TB \_\_\_\_ Shirt Size Start Date \_\_\_\_\_

\_\_\_\_ RE Input Placement \_\_\_\_\_ Day \_\_\_\_\_ Time \_\_\_\_\_

# OPERATION Breakthrough

## VOLUNTEER AGREEMENT

FOR A BETTER UNDERSTANDING OF WHAT YOU CAN EXPECT AS A VOLUNTEER AND WHAT IS EXPECTED OF YOU BY OUR ORGANIZATION WE ASK THAT YOU READ AND SIGN THE FOLLOWING:

Volunteers play a vital role within our organization and will make a huge impact on the families and children of Operation Breakthrough through any volunteer effort. Volunteer positions will be assigned depending on center and staff needs that suit your interests and capabilities. The Volunteer Department greatly appreciates your voluntary services and will do its very best to ensure that your volunteer experience is what interests you, is rewarding, productive, and safe.

Operation Breakthrough is one of the largest all in one childcare facility in the state of Missouri; 700 children call this center their home away from home 5 days a week all year round. The majority of families and children that we serve are living in poverty and have experienced multiple traumas in their lifetime. 1 out of 5 of our children are living in foster care, a shelter, or with a family member or friend. Our center is often the only stable environment that our children have, so we take extra precautions to ensure that every volunteer who interacts with our children and families understand the impact they have when introduced into their lives. We are looking for committed volunteers to believe in and support our mission.

*We ask for your cooperation in adhering to the following guidelines:*

- I understand that as a volunteer I am here to supply quality assistance to the children, teachers, and staff of Operation Breakthrough.
- I will support the Operation Breakthrough mission, and understand that as a volunteer I am a representative, on and off site, of this organization.
- If volunteering directly with children, I will attend a scheduled orientation, background check consent form, fingerprints, and commit to at least 1 Classroom shift every week for 12 weeks or 2x/month in MakerCity.
- I will respect and promote the unique identity of each child and family and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion, or disability.
- I understand that Operation Breakthrough cannot be held responsible for any damaged, lost, or stolen personal belongings.
- If volunteering with children I will use positive methods of child guidance and will not engage in any form of punishment. I understand that no child will be left alone or unsupervised while under my care and that all potential student discipline be referred to staff.
- I will follow Operation Breakthrough's dress code which means wearing a volunteer shirt, badge, and closed toed shoes when at the center in order to promote safety. Shorts/skirts must be knee length. No spaghetti strap shirts or muscle shirts will be allowed.

# OPERATION Breakthrough

## VOLUNTEER AGREEMENT (continued)

- I give my permission to Operation Breakthrough for the use and reproduction of any and all photographs, video or audio recordings taken of me while volunteering. All recorded media, prints; created media from the content shall be the property of Operation Breakthrough.
- I will not photograph any children without the approval of the Volunteer Coordinator; I must maintain confidentiality of all students and their family's information. I understand that cell phone use is not permitted while I am volunteering at the center.
- I understand that as a volunteer in this facility I am required to be a "Mandated Reporter" If I have any concerns or questions regarding the wellbeing of a child I will immediately notify the Volunteer Coordinator.
- I will keep my personal safety and the safety of all children and staff at the forefront of my volunteer activities. I will follow the rules and protocols presented to me, and will listen to staff's direction while volunteering.
- I will let the Volunteer Department know if they can improve the service and support that I receive. I will be open and honest and notify the department if I would like to change my role and/or commitment.
- I will not discuss my personal religious or political views while volunteering.

*I have read and understand the guidelines and statements above, and agree to comply with them while I am a volunteer for Operation Breakthrough. I understand that I can be terminated as a volunteer at any time for any reason, and will be asked to leave the premises if I do not follow the above requirements.*

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**Print Name**

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**Signature**

**Date**

# OPERATION Breakthrough

## DISCLOSURE OF BACKGROUND INVESTIGATION

Operation Breakthrough, Inc. is providing to you this disclosure of our intent to conduct a background investigation for employment purposes. As a childcare services provider, Operation Breakthrough is required by law to perform background checks on individuals who work with or around children enrolled here prior to employment, annually and periodically throughout employment. This applies to volunteers and contractors as well. Under the Fair Credit Reporting Act (FCRA), any written, oral, or other communication of information provided by a Consumer Reporting Agency (CRA) is an investigative consumer report (background screening). Investigative consumer reports also include employment references, information about your personal characteristics, character, general reputation, mode of living, criminal, driving (if applicable) and work history.

Operation Breakthrough will request background investigations prior to employment, annually and periodically throughout employment from the following Consumer Reporting Agencies (CRAs): Missouri Department of Health & Senior Services Family Care Safety Registry (FCSR) and Missouri Volunteer and Employee Criminal History Service (MOVECHS). Their phone numbers are 1-866-422-6872 and 1-573-526-6153, respectively. The following criminal background checks will be included: child/elder abuse or neglect, sex offender registry check, and fingerprints to include both state and federal bureau of investigation criminal checks. A finding of any history of criminal conviction for a sexual offense or child/elder abuse will preclude you from working here. Other matters may prevent you from working here until further investigation and your history is cleared with the state of Missouri.

More information on the nature and scope of the investigation conducted by the CRA will be made available to you should you desire. Operation Breakthrough, Inc. will not provide you information from previous/ past employers, licensing agencies, educational institutions, volunteer agencies, or personal/ professional references not received from CRAs.

Please sign below to acknowledge your receipt of this disclosure.

\_\_\_\_\_  
DATE OF SIGNATURE

\_\_\_\_\_  
PRINT FULL LEGAL NAME

\_\_\_\_\_  
SIGNATURE



## **RELEASE AUTHORIZATION FOR BACKGROUND INVESTIGATION**

In connection with your application to work at Operation Breakthrough as an employee or volunteer, you authorize Operation Breakthrough, Inc. and its background investigation service providers (Consumer Reporting Agencies), to procure and review background checks/consumer reports. You understand such reports will include information regarding state and federal criminal history or child/elder abuse or neglect, and your inclusion in any jurisdiction's registry of sexual offenders.

You also understand that your driving record (if appropriate to your duties), licensure in a specific profession, education, volunteer and employment history and other matters which reflect on your character and general reputation are a part of the background investigation.

The reports may be compiled from credit bureaus, court records, department of motor vehicles, past employers or volunteer service records, educational institutions, governmental license and registration entities, business or personal references, and any other source required to verify information.

The Consumer Financial Protection Bureau's Summary of Rights under the Fair Credit Reporting Act is provided in a separate written document. Your signature below acknowledges your receipt of the document.

You do hereby give consent (authorization) to Operation Breakthrough to request and receive such information prior to employment, annually and periodically throughout employment. You acknowledge that a fax, image, or copy of this authorization is as valid as the original and good for one year.

\_\_\_\_\_  
**PRINT FULL LEGAL NAME**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE OF SIGNATURE**

\_\_\_\_\_  
**ADDRESS**

\_\_\_\_\_  
**CITY, STATE, ZIPCODE**

\_\_\_\_\_  
**SOCIAL SECURITY NUMBER**

\_\_\_\_\_  
**BIRTH DATE**



Missouri State Highway Patrol
Criminal Justice Information Services Division

MOVECHS WAIVER AGREEMENT AND STATEMENT

Missouri Volunteer and Employee Criminal History Service (MOVECHS)
For criminal history record information pursuant to the National Child Protection
Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA),
And the Adam Walsh Child Protection and Safety Act of 2006

Pursuant to the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children
Act (VCA), this form must be completed and signed by every current or prospective applicant, employee,
volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity
under these laws.

I hereby authorize \_\_\_\_\_ Operation Breakthrough
Name of Qualified Entity

to submit a set of my fingerprints to the Missouri State Highway Patrol (MSHP) for the purpose of
accessing and reviewing state and national criminal history records that may pertain to me. I understand
that I would be able to receive any Missouri records pursuant to Chapter 43 RSMo from the MSHP, and
any national criminal history record directly from the Federal Bureau of Investigation (FBI) pursuant to
Title 28 Code of Federal Regulations (CFR) Sections 16.30-16.34, and that I could then freely disclose
any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to
authorize the dissemination of any Missouri and national criminal history record that may pertain to me to
the qualified entity.

I understand that, until the criminal history background check is completed, the qualified entity may
choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further
understand that, upon request, the qualified entity will provide me a copy of the criminal history
background report, if any, received on me and that I am entitled to challenge the accuracy and
completeness of any information contained in any such report. I may obtain a prompt determination as
to the validity of my challenge before a final decision is made.

[ ] Yes, I have (OR) [ ] No, I have not been convicted of or plead guilty to a crime.

If yes, please describe the crime(s) and the particulars:

I am a current or prospective (check one): Applicant [ ] Employee [ ] Volunteer [ ] Contractor/Vendor [ ]

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN (last 4 digits - Optional) Not required

TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

NOTE: This document must be retained by the agency/qualified entity for audit purposes.

Rap Back Notice and Acknowledgment Form

Operation Breakthrough is required to submit background screenings on any individual providing services under the organization’s purview. Background screenings are conducted via live digital fingerprint scans submitted through IDEMIA and registered on the Missouri Automated Criminal History Site (*MACHS*).

As a qualified entity as determined by the Missouri State Highway Patrol (*MSHP*) Criminal Justice Information Services Division (*CJIS*), Operation Breakthrough also participates in the “Rap Back” Program. This is a program that allows Operation Breakthrough to receive updated Missouri and National fingerprint-based criminal arrest information on individuals who are employed or otherwise under our purview (e.g. volunteers or interns).

Your signature below confirms your acknowledgement of Operation Breakthrough’s participation in the Rap Back Program and indicates your agreement to allow Operation Breakthrough access to your updated criminal arrest information throughout the duration of your service with the organization.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Missouri Department of Health and Senior Services  
Bureau of Communicable Disease Control and Prevention  
**Tuberculosis (TB) Risk Assessment Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**A. Please answer the following questions (Sections A & B to be completed by Patient):**

|  |  |
|--|--|
| Have you ever had a positive Mantoux tuberculin skin test (TST)?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been vaccinated with BCG?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a positive Interferon Gamma Release Assay (IGRA) test? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been diagnosed with or treated for TB Disease?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**B. TB Risk Assessment**

|   |  |
|---|--|
| Have you ever had close contact with anyone who was sick with tuberculosis?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever traveled to one or more of the countries listed below? <b>If yes, please CHECK the countries.</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were you born in one of the countries listed below? <b>If yes, please list the country:</b> _____               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What year did you arrive in the United States? _____  |  |

|                      |                      |                |                       |                          |                              |                        |
|----------------------|----------------------|----------------|-----------------------|--------------------------|------------------------------|------------------------|
| Afghanistan          | Cape Verde           | Gabon          | Kuwait                | Myanmar                  | St. Vincent & The Grenadines | Tokelau                |
| Algeria              | Central African Rep. | Gambia         | Kyrgyzstan            | Namibia                  | Sao Tome & Principe          | Tonga                  |
| Angola               | Chad                 | Georgia        | Lao PDR               | Nauru                    | Saudi Arabia                 | Trinidad & Tobago      |
| Anguilla             | Chile                | Ghana          | Latvia                | Nepal                    | Senegal                      | Tunisia                |
| Argentina            | China                | Greenland      | Lesotho               | Nicaragua                | Serbia                       | Turkey                 |
| Armenia              | Colombia             | Guatemala      | Liberia               | Niger                    | Seychelles Sierra Leone      | Turkmenistan           |
| Azerbaijan           | Comoros              | Guinea         | Libyan Arab Jamihirya | Nigeria                  | Singapore                    | Turks & Caicos Islands |
| Bahrain              | Congo                | Guinea-Bissau  | Lithuania             | Niue                     | Solomon Islands              | Tuvalu                 |
| Bangladesh           | Congo DR             | Guam           | Macedonia-TFYR        | Northern Mariana Islands | Somalia                      | Uganda                 |
| Belarus              | Cote d'Ivoire        | Guyana         | Madagascar            | Pakistan                 | South Africa                 | Ukraine                |
| Belize               | Croatia              | Haiti          | Malawi                | Palau                    | South Africa                 | Uruguay                |
| Benin                | Djibouti             | Honduras       | Malaysia              | Panama                   | Sri Lanka                    | Uzbekistan             |
| Bhutan               | Dominica             | Hungary        | Maldives              | Papua New Guinea         | Sudan                        | Vanuatu                |
| Bolivia              | Dominican Republic   | India          | Mali                  | Paraguay                 | Sudan - South                | Venezuela              |
| Bosnia & Herzegovina | Ecuador              | Indonesia      | Marshall Islands      | Peru                     | Suriname                     | Viet Nam               |
| Botswana             | Egypt                | Iran           | Mauritania            | Philippines              | Syrian Arab Republic         | Wallis & Futuna        |
| Brazil               | El Salvador          | Iraq           | Mauritius             | Poland                   | Swaziland                    | Islands                |
| Brunei Darussalam    | Equatorial Guinea    | Japan          | Mexico                | Portugal                 | Tajikistan                   | Yemen                  |
| Bulgaria             | Eritrea              | Kazakhstan     | Micronesia            | Qatar                    | Tanzania-UR                  | Zambia                 |
| Burkina Faso         | Estonia              | Kenya          | Moldova-Rep.          | Romania                  | Thailand                     | Zimbabwe               |
| Burundi              | Ethiopia             | Kiribati       | Mongolia              | Russian Federation       | Timor-Leste                  |                        |
| Cambodia             | Fiji                 | Korea-DPR      | Morocco               | Rwanda                   | Togo                         |                        |
| Cameroon             | French Polynesia     | Korea-Republic | Mozambique            |                          |                              |                        |

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/topics/tuberculosis/en/>.

|   |   |
|---|---|
| Have you ever had an abnormal chest x-ray suggestive of TB?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Are you HIV positive?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Are you an organ transplant recipient or donor?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |
| Are you coughing up blood or phlegm?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Response |

**I hereby certify** that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Patient Signature (Required)

\_\_\_\_\_  
Date:



Missouri Department of Health and Senior Services  
 Bureau of Communicable Disease Control and Prevention  
**Tuberculosis (TB) Risk Assessment Form**

**C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)**

**Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.**

- Tuberculin Skin Test (TST)** - Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm) of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation\* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

|                                       |   |
|---------------------------------------|---|
| <b>Date Given:</b> _____              | <b>Date Read:</b> _____                           |
| <b>Result:</b> _____ mm of Induration | <b>*Interpretation:</b> Positive____ Negative____ |
| <b>Date Given:</b> _____              | <b>Date Read:</b> _____                           |
| <b>Result:</b> _____ mm of Induration | <b>*Interpretation:</b> Positive____ Negative____ |

**\*TST Interpretation Guidelines (Please check all that apply).**

- |   |   |
|---|---|
| <p><b>&gt;5 mm is Positive:</b> <input type="checkbox"/> Recent close contacts of an individual with infectious TB</p> <p><input type="checkbox"/> Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease</p> <p><input type="checkbox"/> Organ transplant recipients</p> <p><input type="checkbox"/> Immunosuppressed persons: taking <math>\geq 15</math> mg/d of prednisone for <math>\geq 1</math> month; taking a TNF-<math>\alpha</math> antagonist</p> <p><input type="checkbox"/> Persons with HIV/AIDS</p> | <p><b>&gt; 10 mm is Positive:</b> <input type="checkbox"/> Persons born in a high prevalence country or who resided in one for a significant amount of time</p> <p><input type="checkbox"/> History of illicit drug use</p> <p><input type="checkbox"/> Mycobacteriology laboratory personnel</p> <p><input type="checkbox"/> History of resident, worker or volunteer in high-risk congregate settings</p> <p><input type="checkbox"/> Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (&gt;10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes</p> <p><input type="checkbox"/> Children &lt; 4 years of age</p> <p><input type="checkbox"/> Children and adolescents exposed to adults in high-risk categories</p> |
|---|---|
- >15 mm is Positive:**  Persons with no known risk factors for TB disease

- Interferon Gamma Release Assay (Please check the IGRA that is used)**

QFT-G  QFT-GIT  **Date Obtained:** \_\_\_\_\_

**Result:**  Responsive (TB Infection Likely)  Nonresponsive (TB Infection Unlikely)  Indeterminate

T- Spot  **Date Obtained:** \_\_\_\_\_

**Result:**  Negative  Positive  Borderline/Equivocal

Other: \_\_\_\_\_ **Date Obtained:** \_\_\_\_\_ **Result:** \_\_\_\_\_

- Chest X-ray: (Required if TST or IGRA is positive)**

**Date of Chest X-ray:** \_\_\_\_\_ **Result:**  Normal  Abnormal

**Abnormal Chest X-ray Interpretation:** \_\_\_\_\_

- Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis, please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.**

|                                |                            |                              |                                |                            |                              |
|--------------------------------|----------------------------|------------------------------|--------------------------------|----------------------------|------------------------------|
| <b>1. Date Obtained</b> _____  | <b>Smear Result:</b> _____ | <b>Culture Result:</b> _____ | <b>2. Date Obtained:</b> _____ | <b>Smear Result:</b> _____ | <b>Culture Result:</b> _____ |
| <b>3. Date Obtained:</b> _____ | <b>Smear Result:</b> _____ | <b>Culture Result:</b> _____ |                                |                            |                              |

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory, for further testing questions call 573-751-3334.

**I have reviewed the above information with the patient and deemed:**  **No Further Evaluation Needed**  **Further Evaluation is Needed**

\_\_\_\_\_  
 Health Care Provider Signature (Required)

\_\_\_\_\_  
 Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION

**MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF**

- Patient may:  Have contact with children (infant through school-age) in care away from their own homes.  
 Be responsible for children's physical care and social development during day and/or nighttime hours.  
 Need to lift children.

**IDENTIFYING INFORMATION (To be completed by patient.)**

|  |                             |
|--|-----------------------------|
| NAME   | BIRTHDATE                   |
| ADDRESS (STREET, CITY, STATE, ZIP CODE)                | TELEPHONE NUMBER<br>(     ) |
| NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED |                             |

**MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)**

|                             |  |
|-----------------------------|--|
| <b>PHYSICAL EXAMINATION</b> | On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------------|--|

|                     |  |
|---------------------|--|
| <b>TB CLEARANCE</b> | (Check one.)<br><input type="checkbox"/> TB Risk Assessment Form attached (required)<br><input type="checkbox"/> A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____ . |
|---------------------|--|

|                    |  |
|--------------------|--|
| <b>LIMITATIONS</b> | The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:<br><input type="checkbox"/> None<br><input type="checkbox"/> _____ |
|--------------------|--|

|                     |  |
|---------------------|--|
| <b>RESTRICTIONS</b> | This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.<br><input type="checkbox"/> None<br><input type="checkbox"/> _____ |
|---------------------|--|

|                |  |  |
|----------------|--|--|
| <b>REMARKS</b> |  |  |
|----------------|--|--|

**SIGNATURES**

|  |   |   |
|--|---|---|
| SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN        | DATE  | PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.) |
| NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE) | IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.) |   |
|  | TELEPHONE NUMBER<br>(     )   |   |