

**RESULT OF TUBERCULIN TEST  
CHILD DAY CARE CENTER & GROUP DAY CARE HOME PERSONNEL  
(REQUIRED AT TIME OF EMPLOYMENT ONLY)**

NAME OF PERSON: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Results of: Tuberculin skin test  Positive  Negative  
Or  
Chest x-ray  Positive  Negative

Date Administered: \_\_\_\_\_ Date Results Read: \_\_\_\_\_

Signature of Physician\*: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.**

**STATEMENT OF HEALTH STATUS  
CHILD DAY CARE CENTER & GROUP DAY CARE HOME PERSONNEL  
(REQUIRED EVERY TWO YEARS)**

NAME OF PERSON: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

This is to certify that I have examined the above named person and found him/her to be in good health and free from medical or emotional illness or disorder that would currently pose a risk to children in care or interfere with effective functioning as an employee of a child day care facility.

Signature of Physician\*: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.**