Lowndes County
Board of Education Head Start

Volunteer Health Report- HEA 257

Name_____ Date of Birth_____
Address_____

To the examining medical doctor or certified nurse practitioner:
This examination is needed to determine my physical ability to care for and/or have contact with children or to perform services in a child care facility. I authorize you to furnish a report of my examination to **Lowndes County Board of Education Head Start**.

_____ _____
Volunteer's Signature Date

TESTS

Date and result of Intradermal Tuberculin Test: _____

Date and result of chest x-ray: _____

HISTORY of any chronic or communicable disease that may affect his/her ability to care for children or perform services in a child care setting: ( ) YES ( ) NO

PHYSICAL LIMITATIONS that may affect his/her ability to care for children or perform services in a child care setting: ( ) YES ( ) NO

If "YES" to either question, please explain: _____

In my opinion the physical examination reveals that the above-named person is free of any infectious or communicable disease and is physically fit to care for children, to perform services in a child care setting, or to have contact with young children:
( ) YES ( ) NO

If not, please explain: _____

_____ _____
Signature of Medical Provider Date

_____
Address

_____
Telephone Number

R—08/17