

# SAMPLE OF A HEALTHCARE PROVIDER EVALUATION FORM

Used with permission of:



**Minnesota Visiting Nurse Agency**  
 2021 East Hennepin Avenue, Suite 230  
 Minneapolis, MN 55413

Program:	Contact Person:	Phone No.: (    )	Date:
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## To Be Completed By Childcare Provider

Child's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

**HAS**  **HAS NOT** been excluded from our childcare setting. The following signs and/or symptoms have been noted:

- |                                       |                                      |                                       |  |
|---------------------------------------|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Diarrhea    | <input type="checkbox"/> Rash         | <input type="checkbox"/> Respiratory signs |
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Dark urine  | <input type="checkbox"/> Light stool  | <input type="checkbox"/> Coughing/wheezing |
| <input type="checkbox"/> Eye Drainage | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Skin lesions | <input type="checkbox"/> Fever _____       |
- Other concerns in our daily health observation: \_\_\_\_\_

For your information, cases of \_\_\_\_\_ have recently been reported in others attending our program.

## HEALTHCARE PROVIDER, PLEASE EVALUATE THIS CHILD AND COMPLETE THE REMAINDER OF THIS FORM.

## To Be Completed By Healthcare Provider

**Diagnosis** \*Call health department if child has a reportable disease

Not communicable  Communicable \_\_\_\_\_

**Treatment**

None  
 Type \_\_\_\_\_  
 Duration \_\_\_\_\_

**Return To Childcare** \*Call health department if child has a reportable disease

No restrictions  Restricted from childcare until \_\_\_\_\_

**Comments**

\_\_\_\_\_  
 \_\_\_\_\_

Healthcare Provider Signature:	Phone No.: (    )	Date:
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**Parent or guardian must return this completed form to the childcare program when the child returns.**