SAMPLE OF A HEALTH CARE 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:

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:

❑ Vomiting	❑ Diarrhea	❑ Rash	❑ Respiratory signs
❑ Jaundice	❑ Dark urine	❑ Light stool	❑ Coughing/wheezing
❑ Eye Drainage	❑ Mouth sores	❑ Skin lesions	❑ Fever ________

❑ Other concerns in our daily health observation: ______________________________

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

HEALTH CARE PROVIDER, PLEASE EVALUATE THIS CHILD AND COMPLETE THE REMAINDER OF THIS FORM.

To Be Completed By Health Care Provider

Diagnosis *Call health department if child has a reportable disease

❑ Not communicable ❑ Communicable ______________________________

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Treatment

❑ None
❑ Type ______________________________
❑ Duration ______________________________

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

❑ No restrictions ❑ Restricted from childcare until ______________________________

Comments

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Health Care Provider Signature:	Phone No.: ( )	Date:

Parent or guardian must return this completed form to the childcare program when the child returns.