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

<table>
<thead>
<tr>
<th>Program:</th>
<th>Contact Person:</th>
<th>Phone No.:</th>
<th>Date:</th>
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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:

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

☐ Other concerns in our daily health observation:

________________________________________________________________________

☐ 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 __________________________

**Treatment**

☐ None

☐ Type ________________

☐ Duration ________________

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

☐ No restrictions ☐ Restricted from childcare until ________________

**Comments**

________________________________________________________________________

________________________________________________________________________

Health Care Provider Signature: __________________________ Phone No.: (______) Date: ________________

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