The Salvation Army Children's Services Health Appraisal

THIS SECTION TO BE COMPLETED BY RESOURCE FAMILY HOUSEHOLD MEMBER	
Name & Address of Individual Examined:	Purpose of Examination: ❑ Initial Employment ❑ Annual Re-Examination
Name, Address & Phone Number of Agency: The Salvation Army Children's Services 425 Allentown Drive, Suite #1 Allentown, PA 18109 610.821.7706; f: 610.821.8121	Currently or Applying to be: ❑ Resource Parent OR ❑ Household member of Resource Parent ❑ Employee

THE FOLLOWING SECTIONS TO BE COMPLETED BY HEALTH PROFESSIONAL

Part I: As shown by physical, does the individual have:

	YES	NO		YES	NO
1. At least 20/40 combined vision, corrected by glasses, if needed?			5. Normal Respiratory System?		
2. Normal hearing?			6. Normal skin?		
3. Normal blood pressure?			7. Normal Neuro Musculoskeletal Systems?		
4. Normal Cardiovascular System?			8. Normal Endocrine System?		

Please explain all "no" responses above on reverse side of form, giving plan for follow-up.

Part II: Does this individual have any of the following medical problems?

	YES	NO		YES	NO
9. History of myocardial infarction, angina pectoris, coronary insufficiency?			13. Inadequate immune status (Td, measles, mumps, rubella)?		
10. History of Epilepsy?			14. Need for more frequent health visits or sick days than average for age?		
11. Diabetes?			15. Current drug or alcohol dependency?		
12. Thyroid or other metabolic disorders?			16. Disabling emotional disorder?		
17. Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her parenting role? If so, explain on reverse of form.					
18. Does this individual have any special medical problems or communicable disease which might interfere with the health of the children or which might prohibit the individual from providing adequate care for the children? If yes, please explain on reverse of form.					
19. Does this individual present with any mental health, emotional, psychiatric, or psychological needs or diagnoses? If so, explain on reverse of form.					

Please explain all "yes" responses above on reverse side of form, giving plan for follow-up if any.

Part III: Required test for tuberculosis tuberculin skin test by either intracutaneous mamtoux two step method or percutaneous multiple puncture method. Please report test results below or on reverse side, as applicable.

INTRACUTANEOUS MANTOUX TEST METHOD	REPORT OF FIRST TEST	REPORT OF SECOND TEST **IF REQUESTED BY DOCTOR** 1 TO 3 WEEKS LATER
Name of antigen used and manufacturer		
Lot number		
Dose of purified protein derivative		
Date on which test was applied		
Date on which test was read		
Measurement of widest diameter of induration in millimeters		

IF POSITIVE:

Date of report of 14x17 chest x-ray (attach copy of report):	Other studies done to rule out tuberculosis disease:

PERCUTANEOUS MULTIPLE PUNCTURE TEST METHOD	
Name of product used and manufacturer:	Lot number:
Date on which test was applied:	Date on which test was read:
Description of reaction:	
IF VESICULATED:	
Date of report of 14x17 chest x-ray (attach copy of report):	Other studies done to rule out tuberculosis disease:
***NOTE: Any duration without vesiculation must be retested using the Mantoux Method.**	

If significant reaction was reported, the physician report must state that applicant is free from current tuberculosis disease or is under adequate chemotherapy for tuberculosis disease.

Referred for preventative anti-tuberculosis chemotherapy?
_____ Yes **_____ No**

Part IV: Additional comments and/or follow-up required, including explanations from front page:

- Form must be stamped by Doctors office.

_____ _____
Physician Signature Physician Name (Print)

_____ _____
Physician Address & Phone Number Date

Patient Authorization:
The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. Unless prohibited by law, I authorize the physician or other person to disclose my knowledge of information pertaining to my health. I understand that any false or misleading statements may cause termination of my employment.

_____ _____
Patient Signature Date

If Patient is a minor, signature of caregiver is sufficient

Revised 6/2013