ABCD Head Start, 178 Tremont Street, Boston, MA 02111
Phone: (617)348-6272 Fax: (617)357-7158

Head Start Staff Physical Form

Employee Name _____ DOB _____

Address _____ Program _____

1. Mantoux Test (must be within past 12 months - required for new employees only)
Date: _____ **Results:** Negative Positive
If positive, chest x-ray results: Positive Negative

Tuberculosis Risk Assessment Date:_____ Results:_____
(Required for employees after initial employment physical)

2. MMR Immunization Dates: #1 _____ #2 _____
OR

Evidence of immunity from measles, mumps and rubella **(Individuals born in the U.S before 1957. are considered immune and do not need further documents. Individuals born before 1957 in the U.S. territories and outside of the U.S. need 1 dose of MMR vaccine or evidence of immunity from measles, mumps and rubella):**

Blood Test Dates:
Measles: Positive for immunity
Negative for immunity (will need proof of immunizations)

Mumps: Positive for immunity
Negative for immunity (will need proof of immunizations)

Rubella: Positive for immunity
Negative for immunity (will need proof of immunizations)

3. Varicella Childhood Immunization Dates: #1 _____ #2 _____ **OR**

History of Varicella disease (physician diagnosis): **OR**

Serologic evidence of immunity (Blood test date, if any):

4. Date of Physical Examination: _____

Please list any allergies or other health information that the ABCD Head Start program should have:
_____
_____

I certify that I have examined the above person (must be within past 12 months) and have found him/her to be free of communicable disease and able to work with young children. The following conditions apply:
No Limitations
Limitations (**please be specific**): _____

Physician Signature: _____ Date _____
Please print or stamp below.
Physician Name: _____
Address_____
Phone:_____