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:

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.

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 ______________________________

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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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Healthcare Provider Signature:	Phone No.: ( )	Date:

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