EMPLOYEE HEALTH EXAM FORM

Please complete and return form to:
Arrowhead Head Start
702 3rd Avenue South, Virginia, MN 55792
Phone: 218-748-7314 and Fax: 218-735-6959

Employee Name: _____

I allow this health information to be released to Arrowhead Head Start.

Employee Signature: _____ Date: _____

Dear Health Care Provider: Head Start is required to obtain assurance from an employee's health care provider that the employee does not, because of communicable disease, pose a significant risk to the health or safety of others in the program. *[Head Start Performance Standard 1302.93].*

Does this person pose a significant risk to the health or safety of others?

☐ No.
☐ Yes. *Explain and list any needed work accommodations:* _____

_____

Other comments or relevant information: _____

_____

I certify the above work has been completed and is accurate.

Health Care Provider Signature: _____ **Date:** _____

Provider Name: _____

Facilty Address: _____