

**BOWEN AFTER SCHOOL CARE PROGRAM, INC.**  
280 CYPRESS STREET, NEWTON, MA 02459  
617-969-3130

**EMPLOYEE HEALTH FORM**

(To be completed by Physician)

Name of employee \_\_\_\_\_

Date of Physical Examination\* \_\_\_\_\_

Is this employee in good health? \_\_\_\_\_

Does this employee have any physical limitations with regard to working with children?

A. Performing duties? (Leading children to safety in case of an emergency, serving food/drink, dressing children, carrying arts/crafts materials, leading outdoor/gym games, computer/desk work, meeting with parents, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Performing First Aid or CPR to injured child or adult? \_\_\_\_\_

C. Attending to children on Field Trips? \_\_\_\_\_

D. Maintaining set work schedule? (i.e. needs physical therapy, rest, etc.) \_\_\_\_\_

Evidence of immunity (Needs 2 dates the immunity was given)

1. Measles \_\_\_\_\_
2. Mumps \_\_\_\_\_
3. Rubella \_\_\_\_\_

Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

\*Must be within one year prior to employment start date.