

**South Carolina Department of Social Services
Child Care Regulatory Services
MEDICAL STATEMENT**

To be completed by staff, volunteers, and emergency personnel:

Name: _____ SSN: _____
Last First Middle

Home Address: _____
Number Street City State Zip

Date of Birth: _____ Male Female Telephone: _____

Statement of your present health in your own words: _____

Have you ever had or do you now have any of the following:

Illness/Condition	Yes	No	Illness/Condition	Yes	No
Vision Problems			Rupture or Hernia		
Ear, Nose, Throat Problems			Hemorrhoids		
Hearing Loss			Sugar or Albumen in Urine		
Frequent/Severe Headaches			Jaundice		
Dizziness or Fainting Spells			Diabetes		
Head Injury			Heart Problems		
Epilepsy or Seizures			Bone, Joint or other Deformity		
Shortness of Breath or Lung Problems			Back Problems		
Spitting up Blood			Tumor, Growth or Cancer		
Tuberculosis			Nervous Condition		
Skin Disease			Drug or Narcotic Habit		
Pain or Pressure in Chest			Adverse Reaction to Medication		
High Blood Pressure			Alcoholism		
Frequent Indigestion			Illnesses or injury not mentioned above		
Stomach, Liver or Intestinal Problems			Loss of consciousness		
Have you ever been refused employment or been unable to hold a job for reasons of health?					
Have you ever been denied life insurance?					
Have you ever been rejected for or discharged from military service for physical, mental or other reasons?					

If any item is checked "Yes", please explain: _____

Please provide appropriate information below regarding freedom from tuberculosis (TB):

NEW EMPLOYEE: Enter below date of written evidence from a physician or health resource attesting you are free from communicable TB. _____
Date of Verification

CURRENT EMPLOYEE: Check below if you are required to have additional tuberculosis tests.

No more TB tests required TB tests required every _____

I CERTIFY THAT THE ABOVE INFORMATION SUPPLIED BY ME IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature Date