



Health Self-Disclosure

Health Self-Disclosure is to help determine whether direct care staff, any adult living in the facility, and children residing with direct care staff or any adult is physically, emotionally, and mentally able to provide care for children/youth residing in licensed facilities.

Note: The disclosure of a condition that may interfere with the care of or poses a risk to a child in care, the licensee shall provide the Department with a detailed plan that the licensee will implement so the condition does not interfere with the care of the child or mitigates risk.

Form fields for Name (last, first, m.i.), Gender (M/F), Date of Birth, Date Completed, Address, City, State, and ZIP Code.

Answer each of the following statements.

Any past or present major illness, surgeries or treatments? Yes No
If yes, explain:

Any other medical conditions? Yes No
If yes, explain:

Any past or present communicable diseases? Yes No
If yes, explain:

Any current or past medical, physical, or mental health care conditions or treatment that would interfere with the safe care and supervision of a child? Yes No
If yes, List all treatments, adaptive equipment, or other accommodations used to reduce or eliminate any barriers caused by medical, physical, or mental health condition:

Answer each of the following statements. ~ continued

Any past or present drug, substance abuse problem or treatment? Yes No
If yes, explain:

Medications

I regularly use the following prescribed and over-the-counter medications:

Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
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Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use
Prescribed and over-the-counter medications	Reason for use	Prescribed and over-the-counter medications	Reason for use

I do not take any medications.

Signature

By signing this form, I certify that that the information provided above is true, accurate, and complete to the best of my knowledge. I further understand the provision of false information or intentional misrepresentation of information on this form may result in disciplinary action including termination.

_____|_____|_____
Name (Please Print: First, Last, MI) | Signature | Date

Equal Opportunity Employer/Program. The Department of Child Safety (DCS) prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics, or retaliation or any other status protected by federal law, state law, or regulation. Reasonable accommodations to allow a person with a disability to take part in a program, service, or activity are available upon request. To request this document in alternative format or for further information about this policy contact your local office. TTY/TDD Services: 7-1-1. Free language assistance for DCS services is available upon request. Ayuda gratuita con traducciones relacionadas con los servicios del DCS esta disponible a solicitud del cliente.