

# Tanaina Child Development Center

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www.tanainachildren.org

## CHILD CARE STAFF/ OBSERVER

### ANNUAL SELF-PREPARED HEALTH HISTORY

Name of Staff/Observer: \_\_\_\_\_ Date: \_\_\_\_\_  
(type or print)

Position in the Center: \_\_\_\_\_

#### Position Responsibilities

- |   |  |
|---|--|
| <input type="checkbox"/> A. Floater       | <input type="checkbox"/> E. Infants or toddlers                        |
| <input type="checkbox"/> B. Kitchen       | <input type="checkbox"/> F. Preschool age children                     |
| <input type="checkbox"/> C. Food handling | <input type="checkbox"/> G. School age children                        |
| <input type="checkbox"/> D. Ill children  | <input type="checkbox"/> H. Student Observation/ University Assignment |

Brief description of responsibilities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Do you have any health conditions or symptoms (physical, mental, or emotional) that will restrict you from fully performing this job? ["Health conditions" include such concerns as allergies or communicable diseases; "symptoms" include such concerns as dizziness, fainting, seizures, back trouble, disorders of eyes, ears, nose or throat.] YES \_\_\_\_ NO \_\_\_\_
2. If so, what is the condition(s)?
3. How does this condition(s) restrict your care of children or the performance of your job?
4. Are you or have you been in the last year under treatment for any health, drug, alcohol or mental health problems? YES \_\_\_\_ NO \_\_\_\_
5. How does this treatment impact your ability to perform this job?

I understand that health conditions, symptoms or treatments do not necessarily prevent me from working with children. I understand that further evaluations may be required, as defined in AMC 16.55.250, if necessary to determine whether I can perform the job. YES \_\_\_\_ NO \_\_\_\_

My signature indicates that the above information is understood, true and gives an accurate picture of my health as it relates to this job in a child care center.

Signature \_\_\_\_\_ Date \_\_\_\_\_