Nebraska Department of Health and Human Services, Division of Public Health
LICENSURE – CHILDREN'S SERVICES LICENSING
Health Information Report

This Health Information Report must be current within 60 days from the date of the health evaluation.

SECTION A: THIS SECTION TO BE COMPLETED BY THE APPLICANT/PROVIDER. ALL BLANKS MUST BE COMPLETED.			
Name			Birthdate
Street Address	City	State	Zip Code
If applicable, indicate name and address of facility for whom you work:			
Name of Facility			
Street Address	City	State	Zip Code
List all **prescription** medications you are currently taking: (List **NONE** if you are not taking any prescription medications)			
Signature of applicant/provider **SIGN HERE**			Date

SECTION B:	
IF THE ANSWER IS NO TO ANY OF THE QUESTIONS BELOW AND THE INDIVIDUAL IS NOT ON MEDICATION, NOT BEING TREATED FOR HIGH BLOOD PRESSURE OR TESTS POSITIVE FOR URINALYSIS, THIS SECTION CAN BE COMPLETED BY THE REGISTERED NURSE (R.N.).	
Signature of Registered Nurse (R.N.)	Date
Printed Name	Office Address

IF THE ANSWER IS YES TO ANY OF THE QUESTIONS BELOW IN SECTION B, PLEASE EXPLAIN AND INDICATE THE POSSIBLE IMPACT OF THIS INDIVIDUAL'S CONDITION ON CARING FOR CHILDREN. ***THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN, PHYSICIAN'S ASSISTANT, CERTIFIED NURSE PRACTICIONER OR ADVANCED PRACTICE REGISTERED NURSE. ALL BLANKS MUST BE COMPLETED.***

Blood Pressure	Urinalysis Albumin____________ Sugar____________

Has this individual been treated or currently being treated for the following:

Drug Addiction: ❑ Yes ❑ No If yes, give date:_________	Hypertension/ High Blood Pressure: ❑ Yes ❑ No If yes, give date: _________
Alcoholism: ❑ Yes ❑ No If yes, give date:_________	A Communicable Disease: ❑ Yes ❑ No If yes, give date: _________
Mental Illness/Depression: ❑ Yes ❑ No If yes, give date:_________	A condition that may affect his/her ability to care for children: ❑ Yes ❑ No If yes, give date: _________

If this individual is on medication, has a blood pressure higher than 160/95, or the above tests read positive or yes, will this affect his/her ability to care for children? ❑ Yes ❑ No

Signature of Physician/Physician's Assistant/C.N.P./A.P.R.N. **SIGN HERE**			Date
Printed Name of Physician/Physician's Assistant/C.N.P./A.P.R.N.		Telephone Number	
Street Address	City	State	Zip Code

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