Love & Mercy FDC
2 / 159-165 Northumberland St, Liverpool NSW 2170
**Tel:** 02 9601 7594
**Email:** loveandmercy.fdc.nsw01@gmail.com
**ABN** – 41 165 380 085

# Educator Medical Assessment

**Educator's First Name:** _____**Surname:**_____

**Address:** _____

**Home Pone No:** ☐☐☐☐ ☐☐☐☐ **Mobile No:** ☐☐☐☐ ☐☐☐☐ ☐☐☐

**Date of Birth:** ___/___/_____ **Gender:** ☐Male ☐Female **Date:** ___/___/_____

Educator must answer the following question

Do you regularly suffer from or have had:

| | | |
|---|---|---|
| ☐Chest Pain | ☐Hay fever/Sinusitis | ☐Backache |
| ☐Angina/Heart Attack | ☐Asthma | ☐Broken bones |
| ☐Rheumatic Fever | ☐Allergies | ☐Sciatica/Leg pain |
| ☐Pneumonia/Pleurisy | ☐Dermatitis/ Eczema | ☐Neck pain/ trouble |
| ☐Emphysema | ☐Injury at work | ☐Join pain/ arthritis |
| ☐Bronchitis | ☐Sport injury | ☐Diabetes |
| ☐Anxiety/Depression | ☐Dizziness/Fainting | ☐Epilepsy |
| ☐Stroke | ☐Eye disorders | ☐Other Serious illness |
| ☐Hearing loss | ☐Frequent Headaches | |
| ☐Hernia | ☐Muscle trouble | |

If you have ticketed any of the above boxes, please detail condition/injury and treatment:

_____

_____

**Educator's Declaration**

I declare the details provided in this form are true and accurate. I understand that withholding any relevant information or providing false information will automatically disqualify me from employment with Love & Mercy FDC and if I have successfully obtained employment, may render my employment liable for termination.

I understand that completion of this form does not automatically qualify me for employment and that further process including OH & S home inspection and security background check are relevant to commence work shall be required.

**Signature:** _____ **Name:** _____ **Date:** ___/___/_____

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# Educator Medical Assessment

**Dear Doctor/GP/Healthy Professional:**

Love & Mercy Family Day Care has a policy that all educators who will be caring for children will need to provide medical documentation by their GP in order that we are aware of any medical conditions and in essence that we are aware that the educator is fit enough both physically and mentally responsible to look after children. Your patient will need to submit this form to us as part of her/his employment a Love & Mercy Family Day Care.

Patient Name: _____ Examination Date: ___/___/_____

Please state what is the status of your patient's general physical and mental health?

_____
_____

Does the patient have any limitation that will prohibit or limit her/his ability to work with young children? ☐**Yes** ☐**No** if yes please provide details of any of these limitation.

_____
_____

Is the patient immune to?

Measles: ☐**Yes** ☐**No** Mumps: ☐**Yes** ☐**No** Rubella: ☐**Yes** ☐**No**

Are you the patients treating physician/health care professional? ☐**Yes** ☐**No** If yes, how long have you been treating this patient?

_____ If No, how many times have you seen this patient?

_____

**Dr Name: _____ Date: ___/___/_____**

**Address: _____**

**Telephone: _____ Licence Number: _____**

**Dr Signature: _____ Date: ___/___/_____**