Compassion Care In-Home Health

CAREGIVER PHYSICAL FORM

I have examined ***(Caregivers Name)*** _____ on ***(Today's date)*** and have found no physical limitations or conditions that should prevent or interfere with the performance of his/her duties as a caregiver. I have found no apparent signs or symptoms which might pose a health hazard for clients under his/her care and no evidence of a communicable disease.

Client First and Last Name: _____
Date of Birth:
Social Security #: _____
Address: with City, Zip: _____
Cell Phone Number:
Height: _____
Weight: _____
Blood Pressure: _____
Need TB Test Done Today: _____
Temperature: _____
HR/ Pulse: _____
Oxygen Stats (O2Sats): _____

Select one please: ☐ Caregiver ☐ Backup Caregiver

Have you ever had any of the following? Please answer **YES or NO**

Blackouts, Dizzy Spells, or Vertigo? ☐ Yes ☐ No

Vision or Hearing impairments? ☐ Yes ☐ No

High Blood Pressure? ☐ Yes ☐ No

Weight Restrictions for Lifting? ☐ Yes ☐ No

Any Chronic Illness that would prevent you from being a caregiver? ☐ Yes ☐ No

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Physician Printed Name:

Physician Signature:

Physician Office Address:

Physician Office Phone #:

Physician Office Fax #:

Client Signature:

Caregiver's Printed Name:

Caregiver's Signature:

Electronic Signature Disclaimer

Please ensure all information is correct before hitting Submit, as this is a Legal Document, and may be used in legal proceedings. Your signature is made with intent, and by signing your name electronically to this Physical to Work as a Caregiver or Backup Caregiver form, you are agreeing that your signature is the legal equivalent of your manual signature. If you want to opt out of the online Physical to Work as a Caregiver or Backup Caregiver form, or any other online form, please contact the office and paper forms will be sent to you.

Check below to acknowledge that you have read the Electronic Signature Disclaimer above:

☐ Yes, I have read the Electronic Signature Disclaimer above:

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