NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner Name of Child: Date of Birth: Date of Examination:

Name of Child.				/ /	Dat	e of Examination. / /			
Immunizations required for entry into day care Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).									
exempt immunization(s	,	2 nd Date	3 rd Date	4 th Date	_	cth D - t -			
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date / /	2 Date / /	3" Date / /	4 Dati		5 th Date / /			
Polio (IPV or OPV)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date					
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date / /	3 rd Date / /		e OR 1 st Date nths of age) /	(if given on or after			
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date					
Hepatitis B	1 st Date / /	2 nd Date / /	3 rd Date / /						
Measles, Mumps and Rubella (MMR)	1 st Date / /	2 nd Date / /		<u> </u>					
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd Date / /							
Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A									
Type of Immunization:		Date: / /		Type of Immunization:		Date: / /			
Type of Immunization:		Date: / /	Type of Immunization:			Date: / /			
Type of Immunization:		Date: / /	Type of Immunization:		Date: / /				
Tests									
Tuberculin Test Date:	/ /	Mantoux Results:	☐ Positiv	ve □ Negative		mm			
Tuberculin Test Date: / / Mantoux Results: Desitive Negative mm TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.									
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.									
in positive, or in X-ray ordered, attach physician o datement adountenting troublent and follow up.									
_	/ /								
Attach lead level stateme									
Lead Screening (Include		esults)		_					
1 year/ /	Result:		mcg/dL	☐ Venous	☐ Capillary				
2 years/_/			mcg/dL	☐ Venous	☐ Capillary				
Most recent date of lead screening (if different from above):									
/ / Result:		mcg/dL	☐ Venous	☐ Capillary					
Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.									

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT (continued)

Health Specifics		Comments		
Are there allergies? (Specify)	☐ Yes ☐ No			
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No			
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No			
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No			
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No			
Summary of Physical Exam Include special recommendations to child of	day care providers			
On the basis of my findings as indicated a that: he/she is free from contagious and coday care.			☐ Yes ☐ No	
Signature of Examiner		Address		
Please Print Name		City, State, 2	Zip	

Phone

Date

Title