

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
Child Day Care Programs

INSTRUCTIONS:

- A signature is required on **BOTH sides** of this form.
- Only a health care provider (physician, physician's assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please PRINT clearly.

Program Name:		Facility ID Number:	
Person's Name:		Date of Birth:	
Type of Program:	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
ROLE:	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Volunteer <input type="checkbox"/> Employee

Typical Child Day Care Duties

<ul style="list-style-type: none"> • Lifting and carrying children 	<ul style="list-style-type: none"> • Driver of vehicle 	<ul style="list-style-type: none"> • Facility maintenance
<ul style="list-style-type: none"> • Close contact with children 	<ul style="list-style-type: none"> • Food preparation 	<ul style="list-style-type: none"> • Evacuation of children in an emergency
<ul style="list-style-type: none"> • Direct supervision of children 	<ul style="list-style-type: none"> • Desk work 	

----- Following to be completed by Health Care Provider **ONLY** -----

Medical Status

To the best of my knowledge of the above-named individual, I find that:			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA (if only role is volunteer or household member)

For any "YES" responses clarify and/or indicate restrictions:

Signature (physician, physician's assistant, nurse practitioner)

Title

Name (Please PRINT clearly or use office stamp)

Date of Exam

() - _____

Date of Signature

Phone

(Continued on reverse side)

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT *(continued)*

Program Name:
Person's Name:

Facility ID Number:
Date of Birth: / /

INSTRUCTIONS:

- A health care professional (physician, physician's assistant, nurse practitioner or a registered nurse, (as part of their duties at a health care facility) may enter the results in the Tuberculin Test Information section and sign this page.
- Acceptable Tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please PRINT clearly.

----- **Following to be completed by Health Professional ONLY** -----

Tuberculin Test Information

Test Completed	
Test read on:	/ /
Test Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm
If Positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Test NOT Completed	
<input type="checkbox"/> Not Tested. Provide reason: _____	
(Medical Exemption or Contraindication)	
If Test Result was previously Positive, indicate date:	/ / _____ mm/dd/yyyy
If previously Positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature *(physician, physician's assistant, nurse practitioner or registered nurse)*

Name *(Please PRINT clearly or use office stamp)*

() - _____
Phone

Title

/ /

Date of Exam

/ /

Date of Signature

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs:** Return this completed form to your Licensor or Registrar.
- **DCC/SACC programs:** For Directors - return this completed form to your Licensor or Registrar; for all other staff - return the form to the Director for evaluation.