

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: ____/____/____

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). Yes No

| | | | | | |
|---|-----------------------------|-----------------------------|-----------------------------|---|-----------------------------|
| Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP) | 1 st Date / / | 2 nd Date / / | 3 rd Date / / | 4 th Date / / | 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 / / | 4 th Date OR 1 st Date (if given on or after 15 months of age) / / | |
| Pneumococcal 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 / / | | | |
| 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: / / |
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Tests

Tuberculin Test Date: ____/____/____ Mantoux Results: Positive 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.

Lead Screening Date: ____/____/____
 Attach lead level statement
Lead Screening (Include All Dates and Results)

1 year ____/____/____ Result: _____ mcg/dL Venous Capillary
 2 years ____/____/____ Result: _____ 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.

CHILD IN CARE MEDICAL STATEMENT (continued)

| Health Specifics | Comments |
|---|----------|
| Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. Yes No

| | |
|-----------------------|--|
| Signature of Examiner | Address |
| Please Print Name | City, State, Zip |
| Title | Phone _____ / _____ / _____ Date _____ / _____ / _____ |