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. If the only role is a household member, complete front page only.
- 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:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Volunteer ☐ Group Teacher ☐ Assistant Teacher	☐ Employee

Typical Child Day Care Duties

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

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.	☐ YES	☐ NO	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ 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 / /

( ) -
Phone

Date of Signature / /

(Continued on reverse side)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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

Program Name:	Facility ID Number:
Person's Name:	Date of Birth:

INSTRUCTIONS:

- Household members in a family-based program that have no other role do not need to have a Tuberculin Test and do not need to complete this page.
- 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: ____/____/____
(mm / dd / yyyy)

Test Result: ☐ Positive ☐ 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? ☐ Yes ☐ No

Test Not Completed

☐ 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?
☐ Yes ☐ No

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

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

( ) - ____/____/____
Phone **Date**

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.