## 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 requir Medical Exemption The immunizations we exempt immunization(s	he physical con vould endange	dition of the nam				☐ Yes ☐ No					
• • •	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Da	nto	5 <sup>th</sup> Date					
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	/ /		/ /	1		/ /					
Polio (IPV or OPV)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Da							
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date	15 m	ete <b>OR</b> 1 <sup>st</sup> Donths of age	Pate (if given on or after e)					
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Da							
Hepatitis B	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /			<u></u>					
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /									
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /									
Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A											
Type of Immunization:		Date: / /		munization:		Date: / /					
Type of Immunization:		Date: / /	Type of Im	munization:		Date: / /					
Type of Immunization:		Date: / /	Type of Im	munization:		Date: / /					
Tests											
Tuberculin Test Date:	1 1	Mantoux Results:	<del></del>	/e ☐ Negative		mm					
TB Tests are at the physic	cian's discretion.	Acceptable tests i	nclude Mant	oux or other fed	lerally app	roved test.					
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.											
	1 1										
Attach lead level stateme Lead Screening (Include		Results)									
1 year/_/	Result:		mcg/dL	☐ Venous	☐ Cap	oillary					
years / / Result:				☐ Venous ☐ Cap		oillary					
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						
Include special recommendations to child o	pay care pro	oviders						
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								
Signature of Examiner			Address					
Please Print Name			City, State, Zip					

Phone

Date

Title