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:
FORMTEXT	FORMTEXT / FORMTEXT / FORMTEXT	FORMTEXT / FORMTEXT / FORMTEXT

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).

FORMCHECKBOX Yes FORMCHECKBOX No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT	3rd Date FORMTEXT / FORMTEXT / FORMTEXT	4th Date FORMTEXT / FORMTEXT / FORMTEXT	5th Date FORMTEXT / FORMTEXT / FORMTEXT
Polio (IPV or OPV)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT	3rd Date FORMTEXT / FORMTEXT / FORMTEXT	4th Date FORMTEXT / FORMTEXT / FORMTEXT	
Haemophilus influenzae type B (Hib)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT	3rd Date FORMTEXT / FORMTEXT / FORMTEXT	4th Date **OR** 1st Date (if given on or after 15 months of age) FORMTEXT / FORMTEXT / FORMTEXT	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT	3rd Date FORMTEXT / FORMTEXT / FORMTEXT	4th Date FORMTEXT / FORMTEXT / FORMTEXT	
Hepatitis B	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT	3rd Date FORMTEXT / FORMTEXT / FORMTEXT		
Measles, Mumps and Rubella (MMR)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT			
Varicella (also known as Chicken Pox)	1st Date FORMTEXT / FORMTEXT / FORMTEXT	2nd Date FORMTEXT / FORMTEXT / FORMTEXT			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
FORMTEXT	FORMTEXT / FORMTEXT / FORMTEXT	FORMTEXT	FORMTEXT / FORMTEXT / FORMTEXT

Type of Immunization: FORMTEXT	Date: FORMTEXT / FORMTEXT / FORMTEXT	Type of Immunization: FORMTEXT	Date: FORMTEXT / FORMTEXT / FORMTEXT
Type of Immunization: FORMTEXT	Date: FORMTEXT / FORMTEXT / FORMTEXT	Type of Immunization: FORMTEXT	Date: FORMTEXT / FORMTEXT / FORMTEXT

Tests

Tuberculin Test Date:	FORMTEXT / FORMTEXT / FORMTEXT	Mantoux Results:	FORMCHECKBOX Positive FORMCHECKBOX Negative	FORMTEXT	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:	FORMTEXT / FORMTEXT / FORMTEXT				
Attach lead level statement					
Lead Screening (Include All Dates and Results)					

1 year	FORMTEXT / FORMTEXT / FORMTEXT	Result:	FORMTEXT	mcg/dL	FORMCHECKBOX Venous	FORMCHECKBOX Capillary
2 years	FORMTEXT / FORMTEXT / FORMTEXT	Result:	FORMTEXT	mcg/dL	FORMCHECKBOX Venous	FORMCHECKBOX Capillary
Most recent date of lead screening (if different from above):						
	FORMTEXT / FORMTEXT / FORMTEXT	Result:	FORMTEXT	mcg/dL	FORMCHECKBOX Venous	FORMCHECKBOX 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)	**FORMCHECKBOX** Yes **FORMCHECKBOX** No	FORMTEXT
Is medication regularly taken? (Specify drug and condition)	**FORMCHECKBOX** Yes **FORMCHECKBOX** No	FORMTEXT
Is a special diet required? (Specify diet and condition)	**FORMCHECKBOX** Yes **FORMCHECKBOX** No	FORMTEXT
Are there any hearing, visual or dental conditions requiring special attention?	**FORMCHECKBOX** Yes **FORMCHECKBOX** No	FORMTEXT
Are there any medical or developmental conditions requiring special attention?	**FORMCHECKBOX** Yes **FORMCHECKBOX** No	FORMTEXT

Summary of Physical Exam

Include special recommendations to child day care providers

FORMTEXT

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.	FORMCHECKBOX Yes FORMCHECKBOX No

		FORMTEXT	
Signature of Examiner		Address	
FORMTEXT		FORMTEXT	
Please Print Name		City, State, Zip	
FORMTEXT		(FORMTEXT) FORMTEXT - FORMTEXT	FORMTEXT / FORMTEXT / FORMTEXT
Title		Phone	Date