

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- If the **only role is household member**, complete **only** the front page. If you are a **medical professional**, 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 on the reverse.
- 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.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the NYS Office of Children and Family Services, and/or denial or revocation of a license or registration.

Program name:	Facility ID number:
Person's name:	Date of birth:
Person's signature:	

<u>TYPE OF PROGRAM:</u>	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
<u>ROLE:</u>	<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"/> Volunteer <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Employee

Typical child day care duties

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

() -

/ /

Phone

Date of Signature

(Continued on reverse side)

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OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
CHILD DAY CARE PROGRAMS *(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 his/her 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 care 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.