

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
Child Care Programs

Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete only the front page.
- Only a health care provider (physician, physician 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.

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 New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.

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

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

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:			
They are 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	
They have 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	
They have a physical condition that would prevent them 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 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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Program's Name:
Person's Name:

Facility ID Number:
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. No one with a role in a legally-exempt program needs to complete the tuberculin test.
- 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 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-directors**—return this completed form to your licensor or registrar; all other staff—return the form to the director for evaluation.
- **Directors of legally-exempt group programs**—return this form to your enrollment agency.
- **Employees and volunteers at legally exempt programs**—return this form to your director