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: / /	Da	ate of Examination: / /		
Immunizations requi	_	-	ned child is	such that one o	or more			
of the immunizations	would endange					☐ Yes ☐ No		
exempt immunization(Land D. 1	lord D .	Lath		Leth D		
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria	1 st Date / /	2 nd Date / /	3 rd Date	4 th Dat	te /	5 th Date / /		
and Tetanus and acellular Pertussis (DTaP)	, ,		, ,		,	, ,		
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Dat				
Tollo (II v ol ol v)	/ /	/ /	1 1	1	1			
Haanaahilea infleanna	1 st Date	2 nd Date	3 rd Date	4-		OR 1st Date (if given on or after		
Haemophilus influenzae type B (Hib)	/ /	/ /	/ /	15 mo	15 months of age) / /			
Pnuemococcal Conjugate	1 st Date	2 nd Date	3 rd Date	ate 4 th Date				
(PCV) for those born on or after 1/1/08)	1 1	/ /	/ /	′ /	/			
Hepatitis B	1 st Date	2 nd Date / /	3 rd Date	,		_		
Measles, Mumps and	1 st Date	2 nd Date	, ,					
Rubella (MMR)	/ /	/ /						
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd Date / /						
Other Immunization	s may includ	le the recomm	ended vac	cines of Rota	avirus, In	fluenza and		
Hepatitis A Type of Immunization:		Date:	Type of Im	nmunization:		Date:		
•		/ /				/ /		
Type of Immunization:		Date: / /	Type of Im	nmunization:		Date: / /		
Type of Immunization:	Type of Immunization:		Type of Im	nmunization:		Date: / /		
Tests			•					
Tuberculin Test Date:	1 1	Mantoux Results	□ Booiti	ve Negative		mm		
TB Tests are at the phys	ician's discretion			-		mm wed test		
If positive, or if x-ray orde		•				ved test.		
			J		·			
Lead Screening Date: Attach lead level stateme	/ /							
Lead Screening (Includ		l Results)						
1 year/ /		-	mcg/dL	☐ Venous	☐ Capill	arv		
		esult:		mcg/dL		-		
Most recent date of lea			_			,		
						☐ Capillary		
Per NYS law, a blood le			<u> </u>		•	-		
If the child has not been	tested for lead,	the day care provide	der may not	exclude the child	I from child	day care, but must		
give the parent informati county health departmen			on, and refer	the parent to th	eir health c	are provider or the		

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						
On the basis of my findings as indicated a that: he/she is free from contagious and co							☐ Yes ☐ No	
day care.								
Signature of Examiner						Address		
Please Print Name			City, State, Zip					
			/					