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	or more			
of the immunizations	would endange					☐ Yes ☐ No		
exempt immunization(- i		1	1		1		
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria	1 st Date / /	2 nd Date / /	3 rd Date	4 th Da	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 Da				
Tollo (II v ol ol v)	/ /	/ /	/ /	/	/			
Haemophilus influenzae	1st Date	2 nd Date	3 rd Date	4.5	4th Date OR 1st Date (if given on or after			
type B (Hib)	/ /	/ /	/ /		15 months of age) / /			
Pnuemococcal Conjugate	1st Date	2 nd Date	3 rd Date 4 th Dat		te			
(PCV) for those born on or after 1/1/08)	/ /	/ /	/ /	′ /	/			
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 / /						
	•	<u> </u>						
Other Immunization	s may includ	le the recomm	ended vac	cines of Rot	avirus, In	fluenza and		
Hepatitis A Type of Immunization:		Date:	Type of In	nmunization:		Date:		
Type of immunization.		/ /				/ /		
Type of Immunization:		Date: / /	Type of In	nmunization:		Date: / /		
Type of Immunization:		Date: / /	Type of In	nmunization:		Date: / /		
Tasta		.	1					
Tuberculin Test Date:	/ /	Mantoux Results	Dociti	ve Negative				
TB Tests are at the phys	· ·			ū		mm wed test		
If positive, or if x-ray orde		•				ved test.		
	/ /							
Attach lead level statement Lead Screening (Include		l Results)						
1 year / /		results	mcg/dL	☐ Venous	☐ Capill	arv		
2 years / /			mcg/dL	☐ Venous				
Most recent date of lea			_		_ очь	a.,		
/ /			-	cg/dL		☐ Capillary		
Per NYS law, a blood le	_							
If the child has not been	tested for lead,	the day care provi	der may not	exclude the child	d from child	day care, but must		
give the parent informati county health departmen			on, and refer	the parent to th	neir health c	are provider or the		

OCFS-LDSS-4433 (Rev. 06/2019) CHILD IN CARE MEDICAL STATEMENT (continued)

lealth Specifics					Comm	ents	
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 c							
day care.		2.20430			- x s. parc	5.1114	☐ Yes ☐ No
Signature of Examiner			Address				
Please Print Name			City, State, Zip				
Title			()	- Phone		/ /