## 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

To be completed by	Lioonioca i	nyololan, i myol	oluli Abbi	otant or n	· a · o · · ·	aotitionioi	
Name of Child:			Date of		th:	Date of Examination: / /	
Immunizations requir	ed for entry ir	nto dav care			<u>.</u>		
Medical Exemption T	-	-	ed child is	such that or	ne or mor	те — —	
of the immunizations v							
exempt immunization(s	•				, ,		
Diphtheria, Tetanus and	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup>	¹ Date	5 <sup>th</sup> Date	
Pertussis (DPT) Diphtheria	1 1	1 1	1 1		/ /	1 1	
and Tetanus and acellular Pertussis (DTaP)							
· ortuosis (D · ai )	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup>	¹ Date		
Polio (IPV or OPV)	/ /	/ /	/ /		/ /		
	, ,					st D + ('C' '	
Haemophilus influenzae	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			Date <b>OR</b> 1 <sup>st</sup> Date (if given on or after months of age)		
type B (Hib)	/ /	/ /	/ /		/ /		
Pnuemococcal Conjugate	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	<b>⊿</b> th	¹ Date		
(PCV) for those born on or	/ /	/ /	5 Date		/ /		
after 1/1/08)	, ,	. ,			, ,		
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date				
-	/ /	/ /	/ /				
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /					
Varicella (also known as	1 <sup>st</sup> Date	2 <sup>nd</sup> Date					
Chicken Pox)	1 1	1 1					
	-	1					
Other Immunizations	may includ	e the recomme	nded vac	cines of R	Rotaviru	s, Influenza and	
Hepatitis A	•					•	
Type of Immunization:		Date:	Type of Immunization			Date:	
		1 1					
Type of Immunization:		Date:	Type of Immunization			Date: / /	
Type of Immunization:		Date:	Type of Immunization			Date:	
Type of minumization.		1 1	Type of minianization.			1 1	
		l .				<u> </u>	
Tests							
Tuberculin Test Date:	1 1	Mantoux Results:	☐ Positi	ve 🗌 Nega	ıtivo	mm	
TB Tests are at the physic				•			
		•			_		
If positive, or if x-ray orde	red, allach phys	sician's statement do	cumenting	irealment an	a ioliow-u	).	
Lead Screening Date:	1 1						
Attach lead level stateme							
Lead Screening (Include		Results)					
		-	/ 11			2 :11	
	Result:		mcg/dL			☐ Capillary —	
2 years / /	_		mcg/dL	☐ Venou	Capillary		
Most recent date of lead	l screening (if o	different from abov	e):				
	Result:		mcg/dL Venous			☐ Capillary	
Per NYS law, a blood le				nd wheneve	r risk of le	ead poisoning is likely.	
If the child has not been	tested for lead,	the day care provide	er may not e	exclude the d	child from	child day care, but must	
give the parent information			n, and refer	the parent t	o their hea	alth care provider or the	
county health department	Tor a lead blood	i screening test					

## CHILD IN CARE MEDICAL STATEMENT (continued)

Health Specifics				Comme	nts		
Are there allergies? (Specify)	☐ Yes ☐ N	o —					
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ N	0					
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ N	0					
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ N	0					
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ N	0					
On the basis of my findings as indicated a							
that: he/she is free from contagious and coday care.	ommunicable dise	ase and is	s able to	participate i	n child	☐ Yes ☐ No	
Signature of Examiner			Address				
Please Print Name				City,	State, Zip		
Title		(	)	- Phone		/ / Date	
THE				. 110110		Date	