

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:<br>/ / | Date of Examination:<br>/ / |
|----------------|-----------------------|-----------------------------|

**Immunizations required for entry into day care**

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

|                                                                                               |                             |                             |                             |                                                                                                    |                             |
|-----------------------------------------------------------------------------------------------|-----------------------------|-----------------------------|-----------------------------|----------------------------------------------------------------------------------------------------|-----------------------------|
| Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP) | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / | 3 <sup>rd</sup> Date<br>/ / | 4 <sup>th</sup> Date<br>/ /                                                                        | 5 <sup>th</sup> Date<br>/ / |
| Polio (IPV or OPV)                                                                            | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / | 3 <sup>rd</sup> Date<br>/ / | 4 <sup>th</sup> Date<br>/ /                                                                        |                             |
| Haemophilus influenzae type B (Hib)                                                           | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / | 3 <sup>rd</sup> Date<br>/ / | 4 <sup>th</sup> Date <b>OR</b> 1 <sup>st</sup> Date (if given on or after 15 months of age)<br>/ / |                             |
| Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)                               | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / | 3 <sup>rd</sup> Date<br>/ / | 4 <sup>th</sup> Date<br>/ /                                                                        |                             |
| Hepatitis B                                                                                   | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / | 3 <sup>rd</sup> Date<br>/ / |                                                                                                    |                             |
| Measles, Mumps and Rubella (MMR)                                                              | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / |                             |                                                                                                    |                             |
| Varicella (also known as Chicken Pox)                                                         | 1 <sup>st</sup> Date<br>/ / | 2 <sup>nd</sup> Date<br>/ / |                             |                                                                                                    |                             |

**Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A**

|                       |              |                       |              |
|-----------------------|--------------|-----------------------|--------------|
| Type of Immunization: | Date:<br>/ / | Type of Immunization: | Date:<br>/ / |
| Type of Immunization: | Date:<br>/ / | Type of Immunization: | Date:<br>/ / |
| Type of Immunization: | Date:<br>/ / | Type of Immunization: | Date:<br>/ / |

**Tests**

|                                                                                                                                                                                                                                                                                                            |               |        |                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------|--------------------------------------------------------------------|
| Tuberculin Test Date: / / Mantoux Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm                                                                                                                                                                                    |               |        |                                                                    |
| TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test. If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.                                                                                         |               |        |                                                                    |
| Lead Screening Date: / /                                                                                                                                                                                                                                                                                   |               |        |                                                                    |
| Attach lead level statement                                                                                                                                                                                                                                                                                |               |        |                                                                    |
| <b>Lead Screening (Include All Dates and Results)</b>                                                                                                                                                                                                                                                      |               |        |                                                                    |
| 1 year / /                                                                                                                                                                                                                                                                                                 | Result: _____ | mcg/dL | <input type="checkbox"/> Venous <input type="checkbox"/> Capillary |
| 2 years / /                                                                                                                                                                                                                                                                                                | Result: _____ | mcg/dL | <input type="checkbox"/> Venous <input type="checkbox"/> Capillary |
| <b>Most recent date of lead screening (if different from above):</b>                                                                                                                                                                                                                                       |               |        |                                                                    |
| / /                                                                                                                                                                                                                                                                                                        | Result: _____ | mcg/dL | <input type="checkbox"/> Venous <input type="checkbox"/> Capillary |
| <b>Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.</b>                                                                                                                                                                                   |               |        |                                                                    |
| If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test. |               |        |                                                                    |

(Continued on reverse side)

**CHILD IN CARE MEDICAL STATEMENT** *(continued)***Health Specifics****Comments**

|                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                     |  |
| Is medication regularly taken?<br>(Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No                     |  |
| Is a special diet required?<br>(Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No                        |  |
| Are there any hearing, visual or dental<br>conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Are there any medical or developmental<br>conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |

**Summary of Physical Exam**

Include special recommendations to child day care providers

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On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.

☐ Yes ☐ No

|                                |                                             |
|--------------------------------|---------------------------------------------|
| _____<br>Signature of Examiner | _____<br>Address                            |
| _____<br>Please Print Name     | _____<br>City, State, Zip                   |
| _____<br>Title                 | (     )     -     /     /<br>Phone     Date |