NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Day Care Programs

INSTRUCTIONS:

- A signature is required on **BOTH sides** of this form.
- Only a health care provider (physician, physician's 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.

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

Type of Program:	**Family Day Care, Group Family Day Care and Small Day Care Centers**	**Day Care Center and School-Age Child Care**	**All Programs**
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Group Teacher ☐ Assistant Teacher	☐ Volunteer ☐ Employee

Typical Child Day Care Duties

• Lifting and carrying children	• Driver of vehicle	• Facility maintenance
• Close contact with children	• Food preparation	• Evacuation of children in an emergency
• Direct supervision of children	• Desk work	

---------- **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:			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ Yes	☐ No	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ Yes	☐ No	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	☐ Yes	☐ No	☐ NA *(if only role is volunteer or household member)*

For any "YES" responses clarify and/or indicate restrictions:

Signature *(physician, physician's assistant, nurse practitioner)*

Title

Name *(Please PRINT clearly or use office stamp)*

Date of Exam

( ) -

Phone

Date of Signature

(Continued on reverse side)

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT *(continued)*

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

INSTRUCTIONS:

- A health care professional (physician, physician's assistant, nurse practitioner or a registered nurse, (as part of their 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 Professional ONLY** ----------

Tuberculin Test Information

Test Completed

Test read on: / /

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's assistant, nurse practitioner or registered nurse)*	Title
Name *(Please PRINT clearly or use office stamp)*	/ / Date of Exam
( ) - Phone	/ / Date of Signature

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs:** Return this completed form to your Licensor or Registrar.
- **DCC/SACC programs:** For Directors - return this completed form to your Licensor or Registrar; for all other staff - return the form to the Director for evaluation.