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:		Date of Examination: / /		
I	- d for output into	. day save				
Immunizations requirements Medical Exemption The			ed child is s	such that one	or more	
of the immunizations w	vould endanger					☐ Yes ☐ No
exempt immunization(s	1st Date	2 nd Date	3 rd Date	4 th Da	to	5 th Date
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular	/ /	/ /	/ /	/ /		/ /
Pertussis (DTaP)						
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Da		
	/ /	/ /	/ /		/ 	
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date	3 rd Date	15 mc	te OR 1 st Da onths of age	ate (if given on or after)
Pnuemococcal Conjugate	1 st Date	2 nd Date	3 rd Date	4 th Da		
(PCV) for those born on or after 1/1/08)	1 1	1 1	/ /	/	1	
Hepatitis B	1st Date	2 nd Date	3 rd Date			
Measles, Mumps and Rubella (MMR)	1st Date	2 nd Date				
Varicella (also known as Chicken Pox)	1st Date	2 nd Date				
Chicken Pox)	1 1	1 . 1				
Other Immunization Hepatitis A	s may include	the recomme	ended vac	ccines of Ro	tavirus,	Influenza and
Type of Immunization:		Date:	Type of Im	munization:	Date:	
Type of Immunization:		/ / Date:	Type of Immunization:		/ / Date:	
Type of Infindingation.		/ /			/ /	
Type of Immunization:		Date: / /	Type of Immunization:			Date:
Tests						
Tuberculin Test Date:	1 1	Mantoux Results:	☐ Positiv	/e ☐ Negative		mm
TB Tests are at the physic	cian's discretion.	Acceptable tests in	nclude Mante	oux or other fed	erally appi	oved test.
If positive, or if x-ray orde	red, attach physici	an's statement do	cumenting to	reatment and fo	llow-up.	
Lead Screening Date:	1 /					
Attach lead level stateme						
Lead Screening (Include	e All Dates and R	esults)				
1 year/_/	Result:		mcg/dL	☐ Venous	□ Сар	illary
2 years/_/	Result:	mcg/d		☐ Venous	/enous Capillary	
Most recent date of lead	screening (if diff	ferent from above	e):			
	Result:		mcg/dL	☐ Venous	/enous	
Per NYS law, a blood lead of the child has not been to give the parent information county health department.	tested for lead, the on on lead poisoni	e day care provide ng and prevention	er may not e	exclude the child	I from child	d day care, but must

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						
				3			
On the basis of my findings as indicated a that: he/she is free from contagious and coday care.							
Signature of Examiner			Address				
Please Print Name			City S	tate, Zip			
Floado Filit Hallio		() -	- / /			
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