NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- If the **only role is household member**, complete **only** the front page. If you are a **medical professional**, 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 on the reverse**.
- 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.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the NYS Office of Children and Family Services, and/or denial or revocation of a license or registration.

Program name:	Facility ID number:
Person's name:	Date of birth:
Person's signature:	

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 ☐ Volunteer ☐ Group Teacher ☐ Assistant Teacher	☐ Employee

Typical child day care duties

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

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***)

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STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

CHILD DAY CARE PROGRAMS *(continued)*

Program name:	Facility ID number:
Person's name:	Date of birth:

INSTRUCTIONS:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page.
- A health care professional (physician, physician's assistant, nurse practitioner) *or a registered nurse as part of his/her 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 care professional ONLY

Tuberculin test information

Test completed

Test read on: ____/____/____
(mm / dd / yyyy)

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)*

_____ _____
Name *(please PRINT clearly or use office stamp)* Title

( ) - ____/____/____
Phone Date

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.