OCFS-LDSS-4433 (Rev. 06/2019)

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: / / |
|---|---|---|
| | | |

**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) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | 5th Date / / |
| Polio (IPV or OPV) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | |
| Haemophilus influenzae type B (Hib) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date **OR** 1st Date (if given on or after 15 months of age) / / | |
| Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | |
| Hepatitis B | 1st Date / / | 2nd Date / / | 3rd Date / / | | |
| Measles, Mumps and Rubella (MMR) | 1st Date / / | 2nd Date / / | | | |
| Varicella (also known as Chicken Pox) | 1st Date / / | 2nd Date / / | | | |

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

| | | | |
|---|---|---|---|
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
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## Tests

Tuberculin Test Date: ____/____/____ Mantoux Results: ☐ Positive ☐ 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

**Lead Screening (Include All Dates and Results)**

1 year ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Most recent date of lead screening (if different from above):**

____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.** 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) | ☐ 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 | |

## Summary of Physical Exam

Include special recommendations to child day care providers

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

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date