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.

Facility ID number:

riogram name.			Tability is number.		
Person's name:			Date of birth:		
Person's signature:					
TYPE OF PROGRAM: Family Day Care, Group Family Day Care Pamily Day Care Centers		Day Care Center and School-Age Child Care			All Programs
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)		ctor	☐ Employee	
 Uppical child day Lifting and carry Close contact w Direct supervisi Medical status	vith children • Driver of vehicle • Food preparation	•	Facility maintena Evacuation of ch re provider Ol	ildren in a	an emergency
	y knowledge of the above-named indivi	dual, 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 physi providing typical ch	YES	□NO		A (if only role is volunteer usehold member)	
For any "YES" res	ponses, clarify and/or indicate restrictions:				
Signature (physician,	Title / /	1			
() -	clearly or use office stamp)	Date of E	1		
Phone		Date of S	Signature		

(Continued on reverse side)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

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 complete this page. 	no other role do not need to have a tuberculin test and do not need				
 A health care professional (physician, physician's assistant, health care facility, may enter the results in the tuberculin te 	, nurse practitioner) <i>or a registered nurse as part of his/her duties at a</i> est Information section and sign this page.				
Acceptable tuberculin tests include Mantoux or other federa	ally approved tuberculin test.				
 Please PRINT clearly. 					
	by health care professional <u>ONLY</u>				
Tuberculin test information					
Test completed					
Test read on: / / (mm / dd / yyyy)					
(mm / dd / yyyy)					
Test result: ☐ Positive ☐ Negative	mm				
If Positive, does this person's contact with children enrolled in ch	hild 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 / yy	****				
<u> </u>	rolled in child care pose a risk to the children's health and safety?				
☐ Yes ☐ No					
Signature (physician, physician's assistant, nurse practitioner or register	red 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.