

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:	

<u>TYPE OF PROGRAM:</u>	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
<b>ROLE:</b>	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Volunteer <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> 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**

<b>To the best of my knowledge of the above-named individual, I find that:</b>			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA (if only role is volunteer or household member)
<b>For any "YES" responses, clarify and/or indicate restrictions:</b>			

Signature ( <i>physician, physician's assistant, nurse practitioner</i> )	Title
Name ( <i>please PRINT clearly or use office stamp</i> )	/ /
(     ) -	Date of Exam
Phone	/ /
	Date of Signature

*(Continued on reverse side)*

