NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
# STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
**Child Care Programs**

## Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
- Only a health care provider (physician, physician 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.**
- 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 New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.**

| Program's Name: | Facility ID Number: |
|---|---|
| Person's Name: | Date of Birth:  /   / |

| **TYPE OF PROGRAM:** | **Family Day Care, Group Family Day Care, Small Day Care Centers** | **Day Care Center, School-Age Child Care, Legally-Exempt Group Programs** | **All Programs** |
|---|---|---|---|
| **ROLE:** | ☐ Provider   ☐ Substitute<br>☐ Assistant<br>☐ Household Member (GFDC/FDC) | ☐ Director<br>☐ Group Teacher<br>☐ Assistant Teacher | ☐ Employee<br>☐ Volunteer |

## 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: | | | |
|---|---|---|---|
| They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care. | ☐ YES | ☐ NO | |
| They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care. | ☐ YES | ☐ NO | |
| They have a physical condition that would prevent them 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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## Child Care Programs

| | |
|---|---|
| Program's 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. No one with a role in a legally-exempt program needs to complete the turberculin test.

- 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-directors**—return this completed form to your licensor or registrar; all other staff—return the form to the director for evaluation.

- **Directors of legally-exempt group programs**—return this form to your enrollment agency.

- **Employees and volunteers at legally exempt programs**—return this form to your director