IMPORTANT INFORMATION: Your Doctor MUST complete and sign the REVERSE of this form, including the DATE OF EXAMINATION, below. The immunization record MAY then be attached to the Green Form. THANK YOU!

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To be completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunization required for entry into day care Yes ☒ No ☐

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).

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)	
Pneumococcal 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 Chickenpox)	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:
Type of Immunization:	Date	Type of Immunization:	Date:
Type of Immunization:	Date	Type of Immunization:	Date:

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 possible, 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 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 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 Street Address

_____ _____

Please Print Name City State Zip

_____ (____) _____ ____/____/____

Title Phone Date