

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:
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**Immunizations 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)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Polio (IPV or OPV)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date <b>OR</b> 1 <sup>st</sup> Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date	2 <sup>nd</sup> 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      /   /      Mantoux Results:     Positive    Negative      mm

Date: \_\_\_\_\_

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        /   /      Result: \_\_\_\_\_ mcg/dL       Venous       Capillary

years    \_\_\_\_\_

**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) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Is medication regularly taken? (Specify drug and condition) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Is a special diet required? (Specify diet and condition) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Are there any hearing, visual or dental conditions requiring special attention? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Are there any medical or developmental conditions requiring special attention? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

### Summary of Physical Exam

Include special recommendations to child day care providers

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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

### Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the daycare owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.