Diphtheria, Tetanus and Pertussis (DPT) Diphtheria

and Tetanus and acellular Pertussis (DTaP)

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Γ	Date of Birth:		Date of Examination:
		/ /		/ /

Immunizations required for entry into day care

1st Date

1 1

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).

2nd Date

/ /

□ Yes □ No 3rd Date 4th Date 5th Date / / / / 1 1

Polio (IPV or OPV)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date OR 1 st Date 15 months of age) / /	(if given on or after
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Hepatitis B	1 st Date / /	2 nd Date / /	3 rd Date / /		-
Measles, Mumps and Rubella (MMR)	1 st Date / /	2 nd Date / /		-	
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd 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 ⁻		/ /	Mantoux Results:		_ 0	mm
TB Tests ar	e at the physici	an's discretion.	Acceptable tests in	clude Manto	ux or other fede	erally approved test.
If positive, o	or if x-ray ordere	ed, attach physi	ician's statement doc	cumenting tre	eatment and foll	ow-up.
Lead Scree	ning Date:	/ /				
Attach lead	level statement	t				
Lead Scree	ening (Include	All Dates and	Results)			
1 year	/ /	Result:		mcg/dL	U Venous	Capillary
2 years	/ /	Result:		mcg/dL	U Venous	Capillary
Most recen	nt date of lead	screening (if d	lifferent from above	e):		
	/ /	Result:		mcg/dL	U 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)

Comments

Health Specifics		
Are there allergies? (Specify)	□Yes □No	
Is medication regularly taken?		
(Specify drug and condition)	🗌 Yes 🗌 No	

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(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	□ Yes □ No
day care.	

Signature of Examiner	Address				
Please Print Name		City, State, Zip			
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Title		Phone			ate