

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

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|----------------|-----------------------|-----------------------------|
| Name of Child: | Date of Birth: / / | Date of Examination: / / |
|----------------|-----------------------|-----------------------------|

Immunizations required for entry into day care

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). Yes No

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|---|-----------------------------|-----------------------------|-----------------------------|--|-----------------------------|
| Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP) | 1 st Date / / | 2 nd Date / / | 3 rd Date / / | 4 th Date / / | 5 th Date / / |
| 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 (if given on or after 15 months of age) / / | |
| Pneumococcal 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

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|-----------------------|--------------|-----------------------|--------------|
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
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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 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 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 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)

