

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES



# Medical Statement of Child in Childcare

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 OR 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 Date: \_\_\_ / \_\_\_ / \_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm

TB Tests are at the physician's discretion.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE →