

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- A signature is required on **BOTH sides** of this form. If the only role is a household member, complete front page only.
- Only a health care provider (physician, physician's assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

Program Name: <i>Campus Asp Inc./Campus Day Camp</i>	Facility ID Number: 449239
Person's Name:	Date of Birth:

TYPE OF PROGRAM:	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
ROLE:	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Volunteer <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Employee

Typical Child Day Care Duties

- Lifting and carrying children
- Driver of vehicle
- Facility maintenance
- Close contact with children
- Food preparation
- Evacuation of children in an emergency
- Direct supervision of children
- Desk work

————— **Following to be completed by Health Care Provider ONLY** —————

Medical Status

To the best of my knowledge of the above-named individual, I find that:			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA (if only role is volunteer or household member)
For any "YES" responses, clarify and/or indicate restrictions:			

Signature (physician, physician's assistant, nurse practitioner)

Title

Name (Please PRINT clearly or use office stamp)

Date of Exam

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Date of Signature

Phone

(Continued on reverse side)