**OCFS-6004** (7/2015) FRONT

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:  |  | Facility ID Number: |
| 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:** | [ ]  Provider  | [ ]  Substitute | [ ]  Director | [ ]  Volunteer | [ ]  Employee |
| [ ]  Assistant |  | [ ]  Group Teacher  |
| [ ]  Household Member (GFDC/FDC)  | [ ]  Assistant Teacher |

**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. | [ ]  YES  | [ ]  NO  |  |
| He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care. | [ ]  YES  | [ ]  NO  |  |
| He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above. | [ ]  YES  | [ ]  NO | [ ]  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** |
| (     )     - |  |    /   /      |
| **Phone**  |  | **Date of Signature** |

 *(****Continued on reverse side****)*

**OCFS-6004** (7/2015) REVERSE

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER**

**MEDICAL STATEMENT** *(continued)*

|  |  |  |
| --- | --- | --- |
| Program Name:  |  | Facility ID Number: |
| Person’s Name: |  | Date of Birth: |

**INSTRUCTIONS:**

* Household members in a family-based program that have no other role do not need to have a Tuberculin Test and do not need to complete this page.
* A health care professional (physician, physician's assistant, nurse practitioner or a registered nurse as part of their duties at a health care facility), may enter the results in the Tuberculin Test Information section and sign this page.
* Acceptable Tuberculin tests include Mantoux or other federally approved tuberculin test.
* Please **PRINT** clearly.

**Following to be completed by Health Professional ONLY**

Tuberculin Test Information

|  |
| --- |
| Test Completed |
| Test Read on: |    /    /      |  |
|  | (mm / dd / yyyy) |  |
| Test Result: | [ ]  Positive | [ ]  Negative |       | mm |
| If Positive, does this person’s contact with children enrolled in child care pose a risk to the children’s health and safety? [ ]  Yes [ ]  No |

Test Not Completed

|  |  |
| --- | --- |
| [ ]  Not Tested. Provide reason: |       |
|  |       |
|  | Medical Exemption or Contraindication |
| If test result was previously Positive, indicate date: |    /    /      |  |
|  | (mm / dd / yyyy) |  |
| If previously Positive, does this person’s contact with children enrolled in child care pose a risk to the children’s health and safety?[ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Signature** *(physician, physician's assistant, nurse practitioner or registered nurse)*  |  |  |
|  |  |  |
| **Name** *(Please PRINT clearly or use office stamp)* |  | **Title** |
| (     )      -      |  |    /    /      |
| **Phone**  |  | **Date** |

**INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:**

* GFDC/FDC programs: return this completed form to your Licensor or Registrar.
* DCC/SACC programs: for Directors-return this completed form to your Licensor or Registrar; for all other staff - return the form to the Director for evaluation.