**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.