NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

CHILD DAY CARE PROGRAMS *(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 his/her 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 care 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.