**OCFS-6004** (08/2019) FRONT

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT**

**Child Care Programs**

**Instructions:**

* A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
* Only a health care provider (physician, physician 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.

**I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.**

|  |  |  |
| --- | --- | --- |
| Program’s Name:  The Children's Center At Purchase College |  | Facility ID Number:  41379 |
| Person’s Name: |  | Date of Birth:  **/** **/** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Program:** | **Family Day Care, Group Family Day Care, Small Day Care Centers** | | **Day Care Center, School-Age Child Care, Legally-Exempt Group Programs** | **All Programs** |
| **ROLE:** | Provider | Substitute | Director | Employee  Volunteer |
| 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: | | | |
| They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care. | YES | NO |  |
| They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care. | YES | NO |  |
| They have a physical condition that would prevent them 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** (08/2019) REVERSE

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT**

**Child Care Programs**

|  |  |  |
| --- | --- | --- |
| Program’s 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. No one with a role in a legally-exempt program needs to complete the turberculin test.
* 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-directors**─return this completed form to your licensor or registrar; all other staff─return the form to the director for evaluation.
* **Directors of legally-exempt group programs**─return this form to your enrollment agency.
* **Employees and volunteers at legally exempt programs**─return this form to your director