OCFS-LDSS-4433 (Rev. 5/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care Yes No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd	3rd	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd	3rd	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd	3rd	4th Date after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd	3rd	4th Date	
Hepatitis B	1st Date	2nd	3rd		
Measles, Mumps and Rubella (MMR)	1st Date	2nd			
Varicella (also known as Chicken Pox)	1st Date	2nd			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ___/___/___ Mantoux Results: Positive Negative ___ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ___/___/___

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ___/___/___ Result: _____ mcg/dL Venous Capillary

2 years ___/___/___ Result: _____ mcg/dL Venous Capillary

Most recent date of lead screening (if different from above):

___/___/___ Result: _____ mcg/dL Venous Capillary