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

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 TestDate: / / 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

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	Yes No	
Is medication regularly taken? (Specify drug and condition)	Yes No	
Is a special diet required? (Specify diet and condition)	Yes No	
Are there any hearing, visual or dental conditions requiring special attention?	Yes No	
Are there any medical or developmental conditions requiring special attention?	Yes No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. Yes No

Signature of Examiner	Address	
Please Print Name	City, State, Zip	
Title	( ) Phone	Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

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DAY CARE REGISTRATION

Child's Full Name:

Does your child have any allergies? Yes No

If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? Yes No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				Pager Cell Other
				Pager Cell Other
				Pager Cell Other
				Pager Cell Other

Provider/Day Care Facility Name and Address:	CHILD'S FULL NAME:	SEX: Male Female
	CHILD'S HOME ADDRESS:	DATE OF BIRTH: HOME TELEPHONE NUMBER:
	DATE OF ACCEPTANCE:	DATE OF DISCHARGE:
	NAME OF PERSON APPLYING FOR CHILD:	Parent Guardian Caretaker Relative Other HOME TELEPHONE NUMBER: DAYTIME TELEPHONE NUMBER:
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):	

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. Yes No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. Yes No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. Yes No

I agree to review and update this information whenever a change occurs and at least once every six months. Yes No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:

Child Care Pick-up Authorization Form

I give authorization to release my child(ren):

_____

_____

to the following alternative pick-up persons:

_____ _____/_____
Name/Relationship

_____ _____/_____
Name/Relationship

PLEASE NOTE: He/She/They will not be released to any person who does not show a valid photo ID or is under the age of 16. Our staff also reserves the right not to release the above named child(ren) if it is determined that the escort will be unable to transport the child safely for any reason including being under the influence of alcohol or other drugs.

Advanced notice, IN WRITING, must be given to us for your child's file, in the event that you are sending someone new, via text/email this person MUST have a valid photo ID, and a verification phone call may be needed.

_____ _____
Written name - Parent/Guardian Date

_____
Signature of Parent/Guardian Date

Annual update: Parent/Guardian must review this information annually, make necessary changes and initial and date below to verify that the information is current.

Facility ID# _____

Over The Counter Topical Ointments

PROVIDER: _____

GFDC: _____

Child Name: _____ D.O.B: _____

☺ ☺

I _____, give _____
(Parent Name) (Name of Provider)

permission to apply the following:

☐ diaper rash _____ to be applied ___times a day **OR** ☐ as needed
(Name of ointment)

☐ sunscreen _____ to be applied ___times a day **OR** ☐ as needed
(Name of lotion / cream / spray)

☐ insect repellent _____ to be applied ___times a day **OR** ☐ as needed
(Name of repellent)

☐ I will supply the products ☐ Provider will supply the products

Additional Information:

_____

_____

_____

Signature_____ Date_____
(Parent's signature)

Reminder:
This program does not administer prescribed ointments / creams or medications.

Provider: _____

GFDC: _____

Feeding Schedule

For: _____ DOB: _____
(Child's Name)

I _____,
(Parents Name)

☐ Will supply _____, with ____ bottles of prepared
(Name of Provider)

_____ Formula, to be fed ___ times a day.
(Name of formula)

☐ Give permission to the On-Site Provider to prepare _____Formula
(Name of formula)

for ____ Bottles per day, to be fed ___ times a day.

☐ Will also provide:

___ Bottle/s of water, to be fed ___ times a day,
___ Bottle/s of juice, to be fed ___ times a day,
___ Yogurt, to be fed ___ times a day,
___Puree fruit, to be fed ___ times a day,
___Cereal, to be fed ___ times a day by spoon.

Additional Note:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(Parents signature)

Field Trip Permissions

Child Name: _____ Date of Birth: _____

Walking field trips

- ❑ I/We give permission for my child to attend ALL walking field trips. I understand that my child will be supervised at all times both on and off the program site. If any medical attention is necessary, I understand that treatment will be given as specified by this program's Parent Handbook.
- ❑ I/We do NOT give permission for my child to attend ALL walking field trips.

Driving field trips

- ❑ I/We give permission for my child to attend ALL driving field trips. I understand that my child will be supervised at all times both on and off the program site. I understand that the person driving is licensed by the law specified by the State in which the program operates. If any medical attention is necessary, I understand that treatment will be given as specified by this program's Parent Handbook.
- ❑ I/We do NOT give permission for my child to attend ALL driving field trips.

Signature: _____ Date: _____

Printed Name: _____

Facility Number: _____

Photo & Video Release

Child Name: _____ Date of Birth: _____

We occasionally take photos or videos of the children at the program to be able to share with parents, to post in our classroom, and/or to share on our website and other sites for the purpose of marketing the program. We request your permission to use these photos and videos.

As a legal guardian of a child at this program, I agree to the following:

- I understand that my child may be photographed or have video recorded at the program during normal program hours, field trips, or activities.
- I understand that these photographs and/or videos may be used in program newsletters, or shared on our website, Facebook, Instagram, or any other publication.
- I give permission for my child's photographs and/or video to be included on the program's website, Facebook page, Instagram, or any other publication.
- I also acknowledge that if any name is ever associated with a photo or video, that only first names will be used.
- I understand that I have the right to request, in writing, to have a photo removed from the program's website, Facebook, or another location within 30 days.

Photo & video

- ❏ I/We confirm that I/we have read and understood the photo and video release, and agree to have my child's photos shared via the program website, Facebook, Instagram, newsletter, and any other publication.
- ❏ I/We confirm that I/we have read and understood the photo and video release, do NOT agree to have my child's photos shared via the program website, Facebook, Instagram, newsletter, and any other publication.

Signature: _____ Date: _____

Printed Name: _____

Facility Number: _____

Sleeping and Napping Arrangement

You and the provider will fill it out together on your first day.

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7(i) and 417.8(a)(1), and Group Family Day Care 416.7(i) and 416.8(a)(1)].

Child Name: _____ Date of Birth: _____

I understand that my child, while in the care of this program, will be napping on:

- ❑ A cot
- ❑ A mat
- ❑ A bed
- ❑ A crib
- ❑ Other: _____

I understand that my child will sleep in this area of the home: _____

My napping child will have competent supervision at all times, either through (check one):

- ❑ Direct supervision by a caregiver who is in the same room and has direct visual contact OR
- ❑ Indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as doors to all rooms used by the provider.

If my child is an infant, I understand that my child will be placed on their back to sleep.

Parent Signature: _____ Date: _____

Printed Name: _____

Provider Signature: _____ Date: _____

Printed Name: _____

Facility Number: _____