



2024 / 2025 School Year

New York State Office of Children and Family Services Child In Care Medical Statement

Lisa Wrona, Director christclarionps@gmail.com

415 Thornell Road Pittsford, NY 14534 Phone: (585) 381-5091

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

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

Immunizations required for entry into day care

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). Yes No

Table with 6 columns: Immunization Name, 1st Date, 2nd Date, 3rd Date, 4th Date, 5th Date. Rows include Diphtheria, Tetanus and Pertussis (DPT), Polio (IPV or OPV), Haemophilus influenzae type B (Hib), Pnuemococcal Conjugate (PCV), Hepatitis B, Measles, Mumps and Rubella (MMR), and Varicella.

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

Table for other immunizations with columns: Type of Immunization, Date, Type of Immunization, Date.

Tests

Form for tests including Tuberculin Test Date, Mantoux Results, TB Tests, Lead Screening Date, and Lead Screening (Include All Dates and Results) with fields for 1 year and 2 years results and venous/capillary options.



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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.

Health Specifics

Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> 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