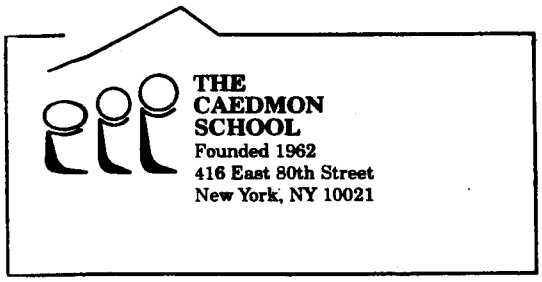

NEW YORK CITY DEPARTMENT OF HEALTH
BUREAU OF DAY CARE

STAFF HEALTH FORM

Pre-employment and annual examination are required for all teaching and non-teaching staff members, including volunteers and students who regularly associate with children. Attach any additional documentation to this form.

Date of Employment _____/_____/_____

(Last)	*(First)*	*(Middle)*	SEX F ☐ M ☐	DATE	DATE OF BIRTH ___/___/___
(No.)	*(Street)*	*(City/Boro)*	*(State)*		*(Zip)*

TELEPHONE: AC ( )	JOB TITLE	AREA EMPLOYED

PAST MEDICAL HISTORY
Please check YES or NO

YES	NO	
☐	☐	Hypertension.
☐	☐	Heart Disease
☐	☐	Diabetes
☐	☐	Seizure Disorder
☐	☐	Chronic Lung Disease
☐	☐	Mental Illness
☐	☐	Alcohol Abuse
☐	☐	Substance Abuse
☐	☐	Physical Disabilities
☐	☐	Allergies
☐	☐	Hepatitis
☐	☐	OTHER (SPECIFY) _____

Please explain any positive findings, list and explain any chronic medications or therapies:

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL PROVIDER SECTION

PHYSICAL EXAM: *(Please note any conditions or findings considered abnormal or requiring medical follow-up)*

Height _____

Weight _____

Blood Pressure _____ / _____

TUBERCULIN TESTING (Must *be filled* out)

DATE TESTED: _____

ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)

DATE INTERPRETED: _____

RESULTS: _____

DATE: _____

DATE: _____

Staff exempt from testing only if they:
Previously had a positive reaction to a PPD/Mantoux tuberculin test or history of TB

History of BCG vaccine does not exempt a staff member from TB screening.
All positive tuberculin tests in persons whose previous PPD/Mantoux was negative require a chest X-ray and treatment started. All previously positive tuberculin tests (PPD Mantoux 10 mm or over) require a report of one chest X-ray, (H.C. 4[illegible].06).

CHEST X-RAY: DONE AT: _____ TREATMENT: _____

DATE: _____ RESULTS: _____

IMMUNIZATION RECORD (Choose as appropriate) ▶	History of Vaccine	History of Illness	Vaccine Given (Date)	Lab Test Of Immunity	Not Applicable
Tetanus/diphtheria (Td) (every 10 yrs.)					
Polio (school age or under 18 yrs.)					
Measles (born after 1956)			or		
Mumps (born after 1956)			or		
Rubella			or		

LABORATORY TESTS (Optional) (Specify tests *ordered*)	DATE	RESULTS

DIAGNOSIS/PROBLEM	**PLAN/FOLLOW-UP** *(For each diagnosis)*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

On the basis of my findings as indicated above and my knowledge of the staff member, I find that the above person is fit to give adequate child care to children in a day care setting at this time.

Provider's Name (Print) _____ License No. _____ Telephone No. _____
(Of Supervisor if NP or PA)

Address: _____

Provider's Signature: _____ Date of Exam: _____

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other records. Records of required medical examinations must be kept on file at the day care center as long as staff members are employed. They must be returned to them upon their request when their employment is terminated. In cases where chest x-rays are required, x-ray reports must be kept on file at the day care center as long as the person is employed and two years thereafter.
(New York City Health Code Section 45.09)