

## MEDICAL STATEMENT OF CHILD IN CHILDCARE

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

<b>Name of child</b>	<b>Date of Birth</b>	<b>Date of Exam</b>
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**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)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Polio (IPV or OPV)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Haemophilus influenza type B (Hib)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date OR 1 <sup>st</sup> Date if after 15months	
Pneumococcal Conjugate (PCV) or those born on or after 1/1/08	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella (Also known as Chicken Pox)	1 <sup>st</sup> Date	2 <sup>nd</sup> 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 Test Date:** \_\_\_/\_\_\_/\_\_\_ **Mantoux Results:** \_\_\_Positive \_\_\_Negative

**TB Tests are at the physician's discretion.**

**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

**1 Year** \_\_\_/\_\_\_/\_\_\_ **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.

**HEALTH SPECIFICS**

**COMMENTS**

**Are there any allergies? Specify** \_\_\_Yes \_\_\_No

\_\_\_\_\_

**Is medication taken regularly? 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 attn?** \_\_\_Yes \_\_\_No

\_\_\_\_\_

**Are there any medical or developmental Conditions requiring special attn?** \_\_\_Yes \_\_\_No

\_\_\_\_\_

\_\_\_\_\_

Big Chief School and Camp  
2427 North Jerusalem Road  
East Meadow, NY 11554

**SUMMARY OF PHYSICAL EXAM**

Include special recommendations to Day Care Providers

Is Child Free of Head Lice \_\_\_\_\_ Yes \_\_\_\_\_ No

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**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 day care**

\_\_\_\_\_ Yes \_\_\_\_\_ No

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**Signature of Examiner**

**Address**

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**Please print name**

**City State, Zip**

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**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 to 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.

**PERMISSION FOR CAMP AND SCHOOL TRIPS**

I hereby give permission for \_\_\_\_\_ to take school and or camp trips during his/her stay at Big Chief

Signed X \_\_\_\_\_

**EMERGENCY TREATMENT**

I, the undersigned parent or guardian of \_\_\_\_\_ presently attending Big Chief School and Camp, hereby authorize the owners, agents, and/or employees of said school and day camp to secure medical treatment in an emergency for and on behalf of my child. Said medical treatment shall include but not be limited to the securing of an ambulance, admission to the hospital, treatment by a doctor, nurse or other qualified medical person.

The undersigned further agrees to indemnify and hold harmless the said owners, agents and/or employees against any and all claims arising from emergency treatment of said child.

Signed X \_\_\_\_\_

Parent or Natural Guardian of above child

Home Telephone # \_\_\_\_\_

Mother's work # \_\_\_\_\_

Father's Telephone # \_\_\_\_\_

Emergency Name and # \_\_\_\_\_

Do you give permission for your child to have Children's Tylenol or Motrin if deemed necessary?

If yes, Parents signature X \_\_\_\_\_

NOTE: This form must be signed by you in three places. Your doctor must sign. Be sure includes the date of examination. You must sign driving permission for the class or camp trips and emergency treatments if necessary.. **We will not accept any child if we do not have this form on file!!**