

**NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
BUREAU OF DAY CARE**

**ANNUAL STAFF HEALTH FORM**

*Agency Stamp*

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 <input type="checkbox"/> M <input type="checkbox"/>	DATE  <u>      </u> / <u>      </u> / <u>      </u>	DATE OF BIRTH  <u>      </u> / <u>      </u> / <u>      </u>
(No.)	(Street)	(City/Boro)	(State)	(Zip)	
TELEPHONE: AC (        )		JOB TITLE		AREA EMPLOYED	

**PAST MEDICAL HISTORY**

*Please check YES or NO*

**YES    NO**

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension          |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease         |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder      |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Lung Disease  |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness        |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse         |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse       |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical Disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies             |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis             |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 \_\_\_\_\_ / \_\_\_\_\_

TOBACCO USE

☐ Current    ☐ Former    ☐ None

If current, referred for cessation services?

☐ Yes    ☐ No

Counselled re: No Smoking

☐ Yes    ☐ No

**TUBERCULIN TESTING** *(Must be filled out)*

DATE TESTED: \_\_\_\_\_

**ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)**

DATE INTERPRETED: \_\_\_\_\_

RESULTS: \_\_\_\_\_

DATE: \_\_\_\_\_

Staff exempt from testing only if they:

Previously had a positive reaction to a PPD/Mantoux tuberculin test or history of TB

DATE: \_\_\_\_\_

**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. 49.06).


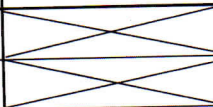
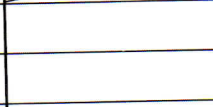

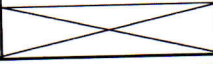

CHEST X-RAY: \_\_\_\_\_

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 <i>(Optional) (Specify tests ordered)</i>	DATE	RESULTS

DIAGNOSIS/PROBLEM	PLAN/FOLLOW-UP <i>(For each diagnosis)</i>
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. \_\_\_\_\_  
(Of Supervisor if NP or PA)

Telephone No. \_\_\_\_\_

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)