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 ❑ 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 ____ / ____

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)*

ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)

DATE TESTED: _____

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 *(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. _____ (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)