



19 Schenectady Ave. 3rd Fl. • Brooklyn, NY 11213 • Tel 347.915.1112 • Fax 347.915.1113

ANNUAL STAFF HEALTH FORM

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

(Last)	(First)	(Middle)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE	DATE OF BIRTH
(Apt. #)	(Street)		(State)		(Zip)

PAST MEDICAL HISTORY

Please check YES or NO

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	Please explain any positive findings, list and explain and chronic medications or therapies _____ _____ _____ _____ _____ _____ _____ _____
<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"/>	Substance Abuse	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify) _____	

MEDICAL PROVIDER SECTION :

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

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

Height: _____

Weight: _____

Blood Pressure: _____/_____

Physicians Stamp
Here

REQUIRED

TUBERCULIN TESTING:

ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)

DATE TESTED : _____

Staff exempt from testing only if they:

DATE INTERPRETED : _____

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

RESULTS: _____

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 10mm or over) require a report of one chest X-ray, (H.C. 49.06)

CHEST X-RAY:

DONE AT: _____

TREATMENT: _____

DATE : _____

RESULTS: _____

REQUIRED

IMMUNIZATION RECORD	History of Illness	Date Vaccine Given	Immune or Non Immune
Measles			
Mumps			
Rubella			

REQUIRED

I, _____, have been informed that the following Vaccinations are recommended by the State and understand I must EITHER provide updated proof of immunity OR refusal for ALL vaccinations that are listed below.

My signature indicates my refusal for all listed immunizations that I have not submitted proof of immunity for.

Signature _____ Date: _____

RECOMMENDED VACCINATIONS	DATE(s) GIVEN	IMMUNE OR NOT IMMUNE
Hepatitis B		
Tetanus - expires every 10 years		
Diphtheria		
Pertussis		
Varicella		
Influenza – expires every year		

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 and free from all communicable disease at this time.

Providers Name (Print) _____ License #. _____ Telephone # _____
(OI Supervisor if NP or PA)

Address: _____

Provider's Signature: _____ Date: _____

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other Records of required medical examinations must be kept on file at the day care 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)