ANNUAL STAFF HEALTH FORM NEW YORK CITY

Los Niños Services
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Los Niños Services
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(LAST)	(FIRST)	(MIDDLE)	(SEX)	(DATE)	(DATE OF BIRTH)

(NO)	(STREET)	(CITY/BORO)	(STATE)	(ZIP)

(TELEPHONE)	(JOB TITLE)	(LICENSE/ CERTIFICATION # IF APPLICABLE)

Past Medical History

Please check Yes or No

Yes	No		
____	____	Hypertension	Please explain any positive findings, list and explain any chronic medications or therapies:
____	____	Heart Disease	
____	____	Diabetes	_____
____	____	Seizure Disorder	_____
____	____	Chronic Lung Disease	_____
____	____	Mental Illness	_____
____	____	Alcohol Abuse	_____
____	____	Substance Abuse	_____
____	____	Physical Disabilities	_____
____	____	Allergies	_____
____	____	Hepatitis	
____	____	Other *(Specify)* _____	

Physical Exam: (Please note any conditions or findings considered abnormal or requiring medical follow up)

Height: _____ Weight: _____ Blood Pressure: _____/ _____

Vaccine Declination Statement:

I, **(print name)** _____, understand that the NYS Department of Health is recommending that providers receive the following vaccines:

_____ Hepatitis B

_____ Diphtheria

_____ Tetanus (Every 10 yrs)

_____ Pertussis

_____ Varicella

_____ Influenza

NOTE: Los Niños Services Early Intervention Program recommended that I follow-up with my own health care provider regarding the recommendation; however, at this time I am **REFUSING** these vaccinations.

Employee Signature: _____ **Date:** _____

ANNUAL TUBERCULIN SKIN TEST- Mantoux/Intermediate PPD (Require annually)

A. Date test administered: _____ Date test read: _____ Results: _____ mm duration

B. If previous tests were negative and the last test was positive, indicate if follow-up Chest x-ray was done:
Date: _____ ☐ Normal ☐ Abnormal
Follow-up/treatment if indicated: _____

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 years)				X	
Polio (school age or under 18 yrs)				X	
Measles (born after 1956)			or		
Mumps (born after 1956)			or		
Rubella	X	X	or		X

RECOMMENDED IMMUNIZATIONS/TITERS:			
Hepatitis B (Indicate dates of all three vaccines)	**Date:**	**Date:**	**Date:**
Varicella	**Date:**		
Pertussis	**Date:**		
Influenza (within the last 12 months)	**Date:**		

LABORATORY TEST (Optional) (Specify test ordered)	DATE:	RESULTS:

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

Primary Care Provider's Signature: _____ License No. _____

Provider's Name (Print): _____ Address: _____

Telephone No._____

Date of Exam: _____

Primary Care Provider's Stamp:

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other records. Records of required medical examination 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-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)

(Revised on 4/10/14)