losniños SERVICES ANNUAL STAFF HEALTH FORM

INSTRUCTIONS: Initial employment and annual examinations are required for all service providers and non-teaching staff members, including volunteers and students who regularly associate with children. Completed annual staff health form must be submitted no more than 20 calendar days from due date to Human Resource Department by email hr@losninos.com or fax 212-787-4418.

STAFF NAME: _____ **DOB:** _____

MEDICAL PROVIDER SECTION

REQUIRED ANNUAL TUBERCULIN TESTING

Tuberculin Skin Test: Mantoux/Intermediate PPD OR Blood Test: Quanteferon Gold

A. Date test administered: _____ Date Interpreted: _____ **Result (Check 1):** ☐ Positive ☐ Negative

B. All positive tuberculin tests in persons whose previous PPD/Mantoux was negative, require a chest x-ray and evaluation if treatment is indicated. All positive tuberculin test (PPD Mantoux 10 mm or over) require a report of one chest x-ray (H.C. 49.06):

Chest X-Ray Date: _____ **Result (Check 1):** ☐ Normal ☐ Abnormal

Follow-up/treatment if indicated: _____

Immunization Record (Indicate as appropriate)	**Vaccine Date(s)**	**Lab Test of Immunity (Check 1: Yes or No)**
Measles, Mumps, Rubella (MMR) (born after 1956)		☐ **YES** ☐ **NO**

REQUIRED ONLY FOR STATEN ISLAND/NYC CENTER

IMMUNIZATIONS/TITERS

Tetanus/Diphtheria/Acellular Pertussis (Tdap)	Date:
Varicella	Date:

RECOMMENDED IMMUNIZATIONS/TITERS

Hepatitis B	Date:	Date:	Date:
Influenza (within the last 12 months)	Date:		
Tetanus/Diphtheria (Td)	Date:		
Tetanus/Diphtheria/Acellular Pertussis (Tdap)	Date:		
Varicella	Date:		

STAFF NAME: _____ **DOB:** _____

MEDICAL PROVIDER SECTION

REQUIRED ANNUAL EXAMINATION

In compliance with the New York State "Health and Safety Standards for Early Intervention Program" Guidance Document, I have examined the above named individual and found that this individual has no diagnosed disorder that would preclude him/her from providing services and is free from communicable disease.

To be completed and signed by a Health care provider, MD, Nurse Practitioner, Physician's Assistant, Nurse Midwife, Advanced Practice Nurse (APN), or Doctors of osteopathic medicine (DOs).

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

***Provider's Signature:** _____

***Date of Exam:** _____

License No. _____

Telephone Number: _____

Address: _____

***Required 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).

STAFF MEMBER SECTION

Vaccine Declination Statement

I, _____**(staff member print name)**, understand that the NYS Department of Health and Los Niños Services Early Intervention Program are recommending that service providers and non-teaching staff members, including volunteers and students who regularly associate with children receive the following vaccines:

- Diphtheria
- Tetanus
- Pertussis
- Hepatitis B
- Varicella
- Influenza

NOTE: My signature below indicates that I have refused to receive some **or** all of the recommended vaccines**.** If I wish to receive **ANY** of these immunizations at a later time, I may do so and will submit updated records to Los Niños Services' Human Resource Department.

Staff Member Signature: _____ **Date:** _____

Required Staff Member Drug/Alcohol Declaration

I am not habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances nor do I have a physical or emotional condition that may alter my behavior, interfere with the performance of my duties or pose a potential risk to patients. The responses above are true to the best of my knowledge. I understand that any omissions, error and/or misstatement of facts may be grounds for termination with Los Niños Services, WCDH contract and/or PCDOH contract.

Staff Member Signature: _____ **Date:** _____

Revised February 19, 2019