Dear Alcott School Staff Member:

As a current staff member at Alcott School, you are required to have an annual physical. The documents that are required for current staff are:

- OCFS form 6004 (two pages) – Staff, Volunteer, and Household Member Medical Statement, signed by a physician, physician assistant, nurse practitioner, or registered nurse;
- Westchester County DOH Health Information Form marked as Attachment F, the Physical Examination Recommended section signed by a licensed health care provider, and the drug and alcohol declaration at the bottom of the signed by you;
- The Tuberculosis Screening and Risk Assessment Form, marked as Appendix F, signed by a licensed health care provider.

Please note that you are not considered to be in compliance until all three of these forms have been completed properly and returned this office.

Thank you for your anticipated cooperation.

Sincerely,

Alcott School Health Services

www.alcottschool.org

535 Broadway, Dobbs Ferry, New York 10522
Phone: 914-693-4443
Fax: 914-693-2820

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
- Only a health care provider (physician, physician assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.

Program's Name:	Facility ID Number:
Person's Name:	Date of Birth: / /

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care, Small Day Care Centers**	**Day Care Center, School-Age Child Care, Legally Exempt Group Programs**	**All Programs**
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Group Teacher ☐ Assistant Teacher	☐ Employee ☐ Volunteer

Typical child day care duties

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

Following to be completed by health care provider ONLY

Medical status

To the best of my knowledge of the above-named individual, I find that:			
They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a physical condition that would prevent them from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ NA *(if only role is volunteer or household member)*
For any "YES" responses, clarify and/or indicate restrictions:			

Signature *(physician, physician assistant, nurse practitioner)* ____________________ Title ____________________

Name *(please PRINT clearly or use office stamp)* ____________________ Date of Exam / /

Phone ( ) - ____________________ Date of Signature / /

(Continued on reverse side)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Program's Name:	Facility ID Number:
Person's Name:	Date of Birth:

Instructions:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page. No one with a role in a legally-exempt program needs to complete the turberculin test.
- A health care professional (physician, physician's assistant, nurse practitioner) *or a registered nurse as part of his/her duties at a health care facility*, may enter the results in the tuberculin test Information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please **PRINT** clearly.

Following to be completed by health care professional ONLY

Tuberculin test information

Test completed

Test read on: ____ / ____ / ________
(mm / dd / yyyy)

Test result: ☐ Positive ☐ Negative ________ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Test not completed

☐ Not tested. Provide reason: ________________________________

____
Medical Exemption or Contraindication

____

If test result was previously positive, indicate date: ____ / ____ / ________
(mm / dd / yyyy)

If previously positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

____
Signature *(physician, physician assistant, nurse practitioner or registered nurse)*

________________________________ ________________
Name *(please PRINT clearly or use office stamp)* Title

(   )   -   ________________ ____ / ____ / ________
Phone Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs**—return this completed form to your licensor or registrar.
- **DCC/SACC programs-directors**—return this completed form to your licensor or registrar; all other staff—return the form to the director for evaluation.
- **Directors of legally-exempt group programs**—return this form to your enrollment agency.
- **Employees and volunteers at legally exempt programs**—return this form to your director

Westchester gov.com

Attachment F

Westchester County Department of Health – Health Information Form

Name: ______________________________ DOB: ___________ Discipline: _____________ License/Certification #: _____________
(Print Name)

REQUIRED

I. Tuberculin Skin Test - Mantoux:

A. Date test administered: __________ Date test read: __________ Results: _______________ mm induration

B. If previous test was negative and the last test was positive, indicate if follow-up Chest x-ray was done.

Date: __________ Normal ☐ Abnormal ☐ Follow-up/treatment if indicated: ____________________

II. **Measles, Mumps, Rubella (MMR)** Date of immunization(s): ____________ or Date of titer and results: ____________

Physical Examination Recommended
(This portion should be completed by your Primary Care Provider)

Health Statement
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.

Primary Care Provider's (stamp):

________________________ (Name) ________________________ (Primary Care Provider Signature) ____________ (Date)

________________________ (Address) ________________________ (Date of Exam)

RECOMMENDED IMMUNIZATIONS/TITERS

Hepatitis B (Indicate dates of all three vaccines): ____________ (Date) ____________ (Date) ____________ (Date)

Tetanus/Diphtheria/Pertussis (Tdap):
Substitute one-time does of Tdap for
Td booster then Td every 10 years
____________ (Date)

Tetanus within past 10 yrs (Td): ____________ (Date)

Varicella: ____________ (Date)

Influenza: ____________ (Date)

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 of my WCDH contract.

Individual Provider's Signature ________________________________ Date: ________________

Rev 3/12

Appendix F: Tuberculosis (TB) Screening and Risk Assessment Form Example

Name: ______________________ Date: ______________________

Preferred Contact Information:

____

1. Have you ever spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
   a. YES, I have been in a foreign country for ≥30 days (not including those listed above)
   b. NO, I have not been in any country for ≥30 days (except the ones listed above)
2. Have you had close contact with anyone who had active TB since your last TB test?
   YES / NO
3. Do you currently have any of the following symptoms?
   a. YES / NO unexplained fever for more than 3 weeks
   b. YES / NO cough for more than 3 weeks with sputum production
   c. YES / NO bloody sputum
   d. YES / NO unintended weight loss >10 pounds
   e. YES / NO drenching night sweats
   f. YES / NO unexplained fatigue for more than 3 weeks
4. Have you ever been diagnosed with active TB disease?
   YES / NO
5. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
   a. YES, one or more of these is true for me
   b. NO none of these is true for me
6. Have you been treated with medication for TB *or* for a positive TB test (e.g., taken "INH")?
   YES / NO
   If YES, what year, with which medication, for how long, and did you complete the treatment course?
   ____
7. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)
   a. YES, one or more of these is true for me
   b. NO, none of these is true for me

______________________________ ______________________
Signature of Licensed Health Care Provider Date

See Example: Appendix 3 at https://links.lww.com/JOM/A782

Recommendations from the American College of Occupational and Environmental Medicine provide additional implementation guidance. Tuberculosis Screening, Testing, and Treatment of US Health... : Journal of Occupational and Environmental Medicine (lww.com)