The New York Institute
For Special Education
999 Pelham Parkway North
Bronx, New York 10469
*Founded in 1831as:The New York
Institute for The Education of The Blind

NEW YORK CITY DEPARTMENT OF HEALTH
BUREAU OF DAY CARE

ANNUAL STAFF HEALTH FORM

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

X

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: ____________________

X

MEDICAL PROVIDER SECTION

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

Height ____________

Weight ____________

Blood Pressure ________/________

X

7K (REV. 5/92)

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: ______

DATE: ______ RESULTS: ______

TREATMENT: ______

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.)				☒	
X Measles (born after 1956)			or		
X Mumps (born after 1956)			or		
X 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)