NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD CARE

Agency Stamp

STAFF HEALTH FORM

Initial employment and every 2 years, a health examination is 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 ____/____/____ Date of Exam ____/____/____

(Last)	*(First)*	*(Middle)*	**SEX** F ☐ M ☐	**DATE**	**DATE OF BIRTH** ____/____/____
(No.)	*(Street)*	*(City/Boro)*		*(State)*	*(Zip)*
TELEPHONE: AC ( )		**JOB TITLE**			**AREA EMPLOYED**

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: _____

MEDICAL PROVIDER SECTION

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

Height _____

Weight _____

Blood Pressure _____/_____

TOBACCO USE	☐ Current	☐ Former	☐ None
If current, referred for cessation services?	☐ Yes	☐ No	
Counselled re: No Smoking	☐ Yes	☐ No	

Staff Name _____ D.O.B._____/_____/_____

TUBERCULIN TESTING *(Not required for employment)*

TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)
OR
BLOOD TEST: QUANTEFERON GOLD

DATE TESTED: _____

DATE INTERPRETED: _____

RESULTS: _____

Staff exempt from testing if they
Had a positive reaction to a PPD/Mantoux test or history of TB. DATE: _____

History of BCG vaccine does not exempt a staff member from TB screening. DATE: _____
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 tests (PPD Mantoux 10 mm or over) require a report of one chest X-ray, (H.C. 49.06).

CHEST X-RAY: DONE AT: _____ TREATMENT: _____

DATE: _____ RESULTS: _____

IMMUNIZATION RECORD
Staff are required to have evidence of immunity to the diseases below through either documented vaccines, blood test documenting immunity, or provider-documented history of illness (except where shaded in grey). Records should be kept in the staff person's file.

Documentation of Immunity	Vaccine Name	Vaccine Date 1	Vaccine Date 2	Blood Test Documenting Immunity (Yes / No)	Provider-Documented History of Illness (Yes / No)
Tdap (Tetanus-diphtheria-acellular pertussis)					
Rubella					
Measles*					
Mumps*					
Varicella*					

*Two doses of vaccine are required at least 28 days apart

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. _____ Telephone No._____
(Of Supervisor if NP or PA)

Address: _____ Date of Exam _____

Provider's Signature _____ Staff Signature _____

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)

BOROUGH OF MANHATTAN COMMUNITY COLLEGE
CITY UNIVERSITY OF NEW YORK
199 Chambers Street
New York, NY 10007

RELEASE FOR EMERGENCY MEDICAL TREATMENT

DIRECTIONS:

1. All students are to print their name, address and telephone number.

2. Students 21 years of age and over are to sign below on the line designated for your signature

3. Student under 21 years of age must obtain parent's/guardian's, etc., where indicated.

STUDENT'S NAME_____

ADDRESS_____ZIP CODE_____

TELEPHONE_____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT WHEN ATTENDING CLASS, PARTICIPATION IN THE WORK-STUDY ASPECT OF THE PROGRAM OR ENGAGED IN ACTIVITIES OF EXTRA-CURRICULA OR CO-CURRICULA NATURE, I HEREBY GIVE PERMISSION TO THE COLLEGE TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR:

Myself_____ My son_____ My daughter_____

(Students 21 years of age or over) _____

Father/Guardian's signature_____

Business address_____

Mother/Guardian's signature_____

Business address_____

Date_____Business telephone_____

Bmcc

TEACHER EDUCATION

Borough of Manhattan Community College
The City University of New York
www.bmcc.cuny.edu

MEDICAL RECORDS FOR EARLY CHILDHOOD EDUCATION PROGRAM –(ROOM S616)

Student Name:_____

Parent/Guardians Name:_____

In Case of an Emergency Notify:_____

Relation to the Student_____ Telephone number:_____

Student Signature:_____

Current Semester of Study: Fall_____Spring_____Winter_____

See attached for complete medical history