Early Childhood Associates
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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	

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 ________/________

TUBERCULIN TESTING (Must be filled out)
ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)

DATE TESTED:____________________
DATE INTERPRETED:____________________

Staff exempt from testing only if they:

Previously had a positive reaction to a PPD/Mantoux tuberculin test or history of TB

DATE:____________________
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 10mm or over) require a report of one chest X-ray. (H.C. 49.06).

CHEST X-RAY
DATE:______________ DONE AT:____________________ TREATMENT:____________________
RESULTS:____________________

IMMUNIZATION RECORD	History of Vaccine	History of Illness	Vaccine Given (Date)	Lab Test of Immunity	Not Applicable
Tetanus / Diptheria (Td) (every 10 years)					
Pertusis					
Measles					
Mumps					
Rubella					
Hepatitis B Vaccine					
Varicella					
Influenza					

LABORATORY TESTS (Optional) (Specify tests ordered)	DATE	RESULTS

DIAGNOSIS/ PROBLEM	PLAN/FOLLOWUP (FOR EACH DIAGNOSIS)
1	
2	
3	
4	
5	

On the basis of my findings as indicated above and my knowledge of the staff member, the individual has no diagnosed disorder that would preclude him/her from providing child care, and is free from communicable disease.

Providers Name (Print)______________________________ Licencse No.______________ Phone______________

Addresss

Providers Signature______________________________ Date of Exam______________