2023 THE HAGEDORN LITTLE VILLAGE SCHOOL 2023

750 Hicksville Road, Seaford, NY 11783 Phone Number (516) 520-6000 Fax Number (516) 520-6084

INITIAL EARLY INTERVENTION Health Form and Medical Statement

TO BE COMPLETED BY EARLY INTERVENTION PROVIDER

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

DOB _____ Position _____

I hereby certify that to the best of my knowledge, I am not currently exhibiting signs of a communicable disease or symptoms suggestive of an emotional or psychiatric disorder that would hinder my job performance working with children with special needs or that would pose a risk to the health and safety of the children in my care. Further, I am physically able to perform the job duties of my position. I attest that I have not forged or altered any information contained in this document or attached to this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime.

Signature_____Date_____

THE SECTION BELOW MUST BE COMPLETED AND SIGNED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER OR REGISTERED NURSE

PLEASE NOTE: If you elect the Mantoux TB Test option, you MUST submit a 2nd Mantoux TB test within 90 days. Contact Janice Gray for procedures.

Mantoux (skin test for tuberculosis) Date PPD Placed: _____ Location - Right Arm ☐ Left Arm ☐

Date PPD Read: _____ Please check one: Negative ☐ Positive ☐

OR

QuantiFERON GOLD Date administered _____ Results check one: Negative ☐ Positive ☐

⇨ **If positive, does this person's contact with children pose a risk to children's health and safety? Yes ☐ No ☐**

⇨ **If previously positive, provide date _____**

⇨ **If prior positive PPD, submit proof that a chest X-ray was completed and clear and that there is a clinical assessment by healthcare provider for no active TB ☐**

⇨ **If PPD not completed – provide reason _____**

Healthcare provider's Signature _____ Date _____

HEALTHCARE PROVIDER PLEASE COMPLETE PAGE 2/REVERSE SIDE

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EI Provider's Name: _____

IMMUNIZATIONS: Please submit proof or complete the information for the following:

Rubella: Date _____ or Results of Titer _____
Measles: Date _____ or Results of Titer _____
Mumps: Date _____ or Results of Titer _____

DOH Highly Recommended Vaccinations	**Date Received**	**Patient Declined (MUST initial)**
Hepatitis B	_____	_____
Tetanus (within last 10 years)	_____	_____
Diphtheria	_____	_____
Pertussis	_____	_____
Varicella (chicken pox)	_____	_____
Influenza	_____	_____

THE SECTION BELOW MUST BE COMPLETED AND SIGNED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Healthcare provider's statement:

I have examined the above named individual and to the best of my knowledge, I find that:
They are not currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of the children in their care. They are not exhibiting signs or symptoms of an emotional or psychiatric disorder, which would pose a risk to the health and safety of the children in their care. They do not have a physical condition that would prevent them from providing typical child day care duties such as lifting and carrying children, direct supervision of children, food preparation, close contact with children, emergency evacuation of children.

Date of Physical Exam _____

Healthcare provider's Signature _____

Healthcare provider's Phone Number _____

Healthcare provider's Name _____

Healthcare provider's Address _____

_____