



7000 Austin Street, Suite 200 • Forest Hills, NY 11375 • Tel 718.762.7633 • Fax 718.886.8694

ANNUAL MEDICAL REQUIREMENT

GENERAL INFORMATION

- Your DOCTOR must completely fill out this form (unless were otherwise indicated in instructions below)
- Medicals missing the required information will be considered incomplete and will need to be re-submitted with the requested information.
- ALL changes made to the form when resubmitted MUST be initialed by your DOCTOR to be accepted as valid.
- NO forms with WHITEOUT will be accepted
- Though other medical forms are acceptable to meet this requirement, ALL information that is required on our form MUST be included.
 - If another form is used, the Achieve Beyond "Recommended Vaccination Acknowledgment" MUST be submitted (click [HERE](#) to download)

How to complete Achieve Beyond's form:

- Page 1
 - All YOUR personal information must be filled out. This can be done by YOUR or your DOCTOR
 - Your Past Medical History must be completed by your DOCTOR
 - Your DOCTOR must stamp the bottom of the page (where indicated). If you he/she does not have a stamp, a signature will be acceptable.
- Page 2
 - Tuberculin Testing (PPD)
 - If you have NEVER received a positive reading you MUST complete this test annually. This can be done in 1 of 2 ways:
 - Skin Test – Dr injects under the skin. You must return to your Dr 48-72 hours later for results to be read
 - Blood Test – Blood is drawn and sent to lab for testing (result time varies on lab)
 - If you HAVE received a positive reading you MUST have 1 of 2 additional tests done (stated below).
 - Blood Test – Blood is drawn and sent to lab for testing
 - Result time varies on lab
 - Good for 1 year
 - Chest X-Ray
 - Result time varies on Radiologist and Doctor
 - Good for UP TO 10 years (This is up to your Dr and results must be written on your medical form EVERY year show your Dr is aware that you are positive and that he/she believes you do not have TB)
 - REQUIRED VACCINATIONS – Measles, Mumps & Rubella (MMR)
 - Section must be completed by your DOCTOR on an annual basis to show that he/she believes you are still immune.
 - Immunity can be shown in 1 of 3 ways:
 - History of Illness
 - Dates of Immunization
 - Titers showing immunity (Blood test - result time varies on lab)
 - RECOMMENDED VACCINATIONS – HepB, Tetanus, Diphtheria, Pertussis, Varicella, Influenza
 - YOU must complete, sign and date top part of this section
 - Your DOCTOR must complete bottom part for any/all immunizations that you may already have (please note expirations of Tetanus and Influenza)
 - Immunity can be shown in 1 or 3 ways:
 - History of Illness
 - Dates of Immunization
 - Titers showing immunity (Blood test - result time varies on lab)
 - Doctor Attestation
 - Your DOCTORS must Sign and write Date of Exam
 - Your DOCTOR can either Stamp or write address/phone/license information



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ANNUAL STAFF HEALTH FORM

Pre-employment and annual examinations are required for all teaching and non-teaching staff members, including volunteers and students who regularly associate with children. Attach additional documentation to this form.

(Last)	(First)	(Middle)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE	DATE OF BIRTH
(Apt. #)	(Street)		(State)		(Zip)

PAST MEDICAL HISTORY

Please check YES or NO

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	Please explain any positive findings, list and explain and chronic medications or therapies _____ _____ _____ _____ _____ _____ _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify) _____	

MEDICAL PROVIDER SECTION :

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

DIAGNOSIS/PROBLEM	PLAN/FOLLOW-UP (For each diagnosis)
1.	1.
2.	2.
3.	3.

Height: _____
 Weight: _____
 Blood Pressure: _____/_____

Physicians Stamp
Here

REQUIRED

TUBERCULIN TESTING:

ANNUAL TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU) DATE TESTED : _____

Staff exempt from testing only if they: DATE INTERPRETED : _____

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

RESULTS: _____

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: DONE AT: _____ TREATMENT: _____

DATE : _____ RESULTS: _____

REQUIRED

IMMUNIZATION RECORD	History of Illness	Date Vaccine Given	Immune or Non Immune
Measles			
Mumps			
Rubella			

REQUIRED

I, _____, have been informed that the following Vaccinations are recommended by the State and understand I must EITHER provide updated proof of immunity OR refusal for ALL vaccinations that are listed below.

My signature indicates my refusal for all listed immunizations that I have not submitted proof of immunity for.

Signature _____ Date: _____

RECOMMENDED VACCINATIONS	DATE(s) GIVEN	IMMUNE OR NOT IMMUNE
Hepatitis B		
Tetanus - expires every 10 years		
Diphtheria		
Pertussis		
Varicella		
Influenza – expires every year		

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 and free from all communicable disease at this time.

Providers Name (Print) _____ License #. _____ Telephone # _____
(OI Supervisor if NP or PA)

Address: _____

Provider's Signature: _____ Date: _____

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other Records of required medical examinations must be kept on file at the day care 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)