ACHIEVE BEYOND
Pediatric Therapy & Autism Services

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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 ☐M ☐F	DATE	DATE OF BIRTH
(Apt. #)	*(Street)*		*(State)*		*(Zip)*

PAST MEDICAL HISTORY

Please check YES or NO

YES	NO		
☐	☐	Hypertension	Please explain any positive findings, list and explain and chronic medications or therapies _____
☐	☐	Heart Disease	_____
☐	☐	Diabetes	_____
☐	☐	Seizure Disorder	_____
☐	☐	Chronic Lung Disease	_____
☐	☐	Mental Illness	_____
☐	☐	Substance Abuse	_____
☐	☐	Allergies	_____
☐	☐	Hepatitis	
☐	☐	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)