

**TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE**  
**2020/2021 MEDICAL REPORT FORM INSTRUCTIONS**

According to New York State Office of Children and Family Services, this is the only form that will be accepted and must be completed entirely. Unfortunately, School District forms cannot be accepted. Medical Form (1 page) is due in our office no later than August 1st.

Please follow instructions below:

1. **Medical Report Form**: Must be filled out completely, signed, stamped and dated by Physician. Physical is not required if child has had one within the last 2 years.

**\*All forms must be filled out according to instructions or it will not be accepted as per OCFS Regulations.\***

# TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE PROGRAM 2020/2021 MEDICAL FORM

NAME OF CHILD: \_\_\_\_\_ NAME OF SCHOOL: \_\_\_\_\_

## Medical Report of Child in Day Care

To Be Completed By Child's Physician, Physician's Assistant or Nurse Practitioner (Other Than A Relative)

Date of Birth:     /     /

Date of Last Exam:     /     /

**HEALTH SPECIFICS:**

**COMMENTS:**

<input type="checkbox"/> Yes <input type="checkbox"/> No   Are there any allergies? If yes, specify what the child is allergic to.	
<input type="checkbox"/> Yes <input type="checkbox"/> No   Is medication regularly taken? (Specify drug & condition)	
<input type="checkbox"/> Yes <input type="checkbox"/> No   Is a special diet required? (Specify diet & condition)	
<input type="checkbox"/> Yes <input type="checkbox"/> No   Are there any hearing, visual or dental conditions requiring special attention?	
<input type="checkbox"/> Yes <input type="checkbox"/> No   Are there any medical or developmental conditions requiring special attention?	

Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?   \_\_\_ Yes   \_\_\_ No

**If yes, describe any additional training, procedures or competencies the day care program staff will need to care for this child.** \_\_\_\_\_

Date of most recent tetanus booster:                                     /     /

**Summary of most recent physical (including special recommendations to Day Care Provider):**

At the time of the child's last exam and on my knowledge of the above named child, I find that he or she is free from contagious and communicable disease and is able to participate in day care.

Yes    No

Signature of Examiner: \_\_\_\_\_ Address: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_