ACHIEVE BEYOND
Pediatric Therapy & Autism Services

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

ANNUAL MEDICAL REQUIREMENT

GENERAL INFORMAITON

- 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.

How to complete Achieve Beyond's form:

- Page 1
    - All YOUR personal information must be filled out. This can be done by YOU or your DOCTOR
    - Your Past Medical History must be completed by your DOCTOR
    - Your DOCTOR must stamp and DATE 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 – **Required Annually for CPSE/CSE, and EI New Hires Only**
        - If you have NEVER received a positive reading you MUST complete this test. 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. The test must be repeated 7 days after the first reading for a total of two skin tests.
            - 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
            - Chest X-Ray
                - Result time varies on Radiologist and Doctor
    - 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
            - Two (2) Doses of MMR Vaccine, with dates
            - Titers showing immunity (Blood test - result time varies on lab)
    - RECCOMENDED VACCINATIONS – HepB, Tetanus, Diptheria (DT,Td,Tdap), Pertussis, Inactive Polio (IPV), Varicella, Influenza and COVID-19
        - YOU must complete, sign and date the 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 DOCTOR must Sign and write Date of Exam
        - Your DOCTOR can either Stamp or write address/phone/license information
    - Tuberculosis Screening – **required annually for EI**
        - YOU must fill out assessment questionnaire (Page 3)
        - Your DOCTOR must review and Sign and write Date Reviewed

PLEASE MAKE SURE TO HAVE YOUR DOCTOR STAMP/SIGN AND DATE ON ALL PAGES

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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	Dates Vaccines 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 (DT, Td, Tdap)				
Pertussis				
Varicella				
Inactive Polio Vaccine (IPV)				
Coronavirus (COVID-19)				
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)

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Tuberculosis Screening and Risk Assessment Form

Instructions: Please answer the questionnaire and have your medical provider, review, sign and date.

Name:_____ **DOB**: _____

1. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
   - **a.** YES I have been in a foreign country for ≥30 days **(not including those listed above)**
   - **b.** NO I have not been in any country for ≥30 days **except the ones listed above**
2. Have you had close contact with anyone who had active TB since your last TB test?
   YES / NO
3. Do you currently have any of the following symptoms?
   a. YES / NO unexplained fever for more than 3 weeks
   b. YES / NO cough for more than 3 weeks with sputum production
   c. YES / NO bloody sputum
   d. YES / NO unintended weight loss >10 pounds
   e. YES / NO drenching night sweats
   f. YES / NO unexplained fatigue for more than 3 weeks
4. Have you ever been diagnosed with active TB disease?
   YES / NO
5. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
   a. YES one or more of these is true for me
   b. NO none of these is true for me
6. Have you been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?
   YES / NO
   If YES, what year, with which medication, for how long, and did you complete the treatment course? _____
7. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)
   a. YES, one or more of these is true for me
   b. NO, none of these is true for me

TO BE FILLED OUT BY YOUR HEALTH CARE PROVIDER

COMMENTS:

_____

_____

_____

REVIEWED BY:

Name: _____ MD, NP, PA, RN

Signature _____ Date: _____

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Recommended Vaccination Acknowledgment

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.

- Hepatitis B vaccine
- Tetanus immunization within the past 10 years
- Diphtheria, tetanus vaccine (DT)
- Tetanus, diphtheria vaccine (Td)
- Tetanus, diphtheria, and acellular pertussis (Tdap)
- Inactive Polio Vaccine (IPV)
- Varicella vaccine
- Influenza vaccine
- Coronavirus vaccine (COVID-19)

It is recommended that EI providers who have opted out of receiving the influenza or COVID-19 vaccines wear a mask when providing services within 6 feet of an enrolled child during periods of time that the New York State Commissioner of Health or the Local Health Department (LHD) determines that influenza season is underway or there is a substantial risk of COVID-19 transmission in the county where services are being provided.

My signature indicates my refusal for all listed immunizations that I have not submitted proof of immunity for and/or my agreement to keep my record up to date for ALL vaccinations that require it.

_____ _____

Signature *Date*