## **Household Member Medical Statement**

## **INSTRUCTIONS**





Submit Maintain On-Site

- Each person residing in the home must have a signed medical statement; a separate form is required for Providers
- One Health Care Provider (Physician, Physician's Assistant or Nurse Practitioner) may sign for multiple household members who are under their care
- A health care provider may use an equivalent form as long as the information on this form is included
- You may duplicate this form as necessary

Applicant Name:		l l			
Household M	lembers Examined	 d by:	· · · · · · · · · · · · · · · · · · ·		
Household Members' Names			Date of Birth	Date of Birth Symptom F	
Last	Final	<del></del>	1 /	☐ Yes	□ No
	First	MI	(mm / dd / yyyÿ)	- □ Yes	□ No
Last	First	MI	(mm / dd / yyyy)	_ □ Yes	
Last	First	MI	(mm / dd / yyyy)	_ LIE2	□ No
I have examined the	(1, 2 or 3) individuals nan	mod shove, and att	and to the findings listed for		
	(1) = 01 0) Individual (10)	Heu above, and all	est to the findings listed for t		
Signature (physician, physician's assistant, nurse practitioner)				//	
Signature (physicia	nn, physician's assistant, nurse	e practitioner)		Date	
		e practitioner)		Date ( ) -	
	n, physician's assistant, nurse	e practitioner)	Title	Oate  ( ) - Phone	
Name (Please PRIN		by:	Title  Date of Birth	()	Free*
Name (Please PRIN	IT or use office stamp) embers Examined lousehold Members' Names	by:	Date of Birth	( ) - Phone	Free*
Name (Please PRIN	IT or use office stamp) embers Examined	by:		( ) - Phone  Symptom  ☐ Yes	□ No
Name (Please PRIN	IT or use office stamp) embers Examined lousehold Members' Names	by:	Date of Birth	Symptom  Yes  Yes	□ No
Name (Please PRIN	embers Examined Household Members' Names	by:	Date of Birth  (mm / dd / yyyy)	( ) - Phone  Symptom  ☐ Yes	□ No
Name (Please PRIN	embers Examined Household Members' Names  First  First  First  (1, 2 or 3) individuals name	MI MI med above, and atte	Date of Birth  (mm / dd / yyyy)  (mm / dd / yyyy)  (mm / dd / yyyy)	Symptom  Yes  Yes  Yes	□ No
Name (Please PRIN	embers Examined Household Members' Names  First  First  First	MI MI med above, and atte	Date of Birth  (mm / dd / yyyy)  (mm / dd / yyyy)  (mm / dd / yyyy)	Symptom  Yes  Yes  Yes	□ No
Name (Please PRIN	embers Examined Household Members' Names  First  First  First  (1, 2 or 3) individuals namen, physician's assistant, nurse	MI MI med above, and atte	Date of Birth  (mm / dd / yyyy)  (mm / dd / yyyy)  (mm / dd / yyyy)	Symptom  Yes  Yes  Yes  Yes	□ No

NYS FDC Booklet #: Form Valid Through:



<sup>\*</sup>The person is free from any health condition that would endanger children receiving child care in the home. Attach documentation for any adverse findings.