

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):	
Section A- EXAMINATION	
☒ The above named child has been examined.	
☒ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).	
☒ The above named child does not have allergies OR is allergic to the following (<i>please list in space below</i>): 	
<i>Check below, if applicable:</i> ☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.	
Optional: Measurements and Recommended Assessments/Screenings Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No BMI _____ Dental _____ ☐ Yes ☐ No Other: _____ Notes:	
Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (Complete ONLY ONE SECTION below) Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: ☐ The above named child has been immunized against the diseases listed above. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	Initials of Examining Health Care Practitioner
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Signature of Parent
	Date