Ohio Department of Job and Family Services

# CHILD MEDICAL STATEMENT FOR CHILD CARE

| Child's Name *(print or type)* | 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 (*please list in space below)*:

*Check below, if applicable:*

☐ 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. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):* | **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 |