Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*

Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner

Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner

Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent

Date of Signature

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements

Height	
Weight	
BMI	

Notes

EMERGENCY CONTACT INFORMATION

STUDENT'S NAME: ____________________

EMAIL ADDRESS: ____________________

DOB : ____________________

FATHER

NAME ____________________

OCCUPATION ____________________

PLACE OF EMPLOYMENT ____________________

WORK # ____________ CELL # ____________

MOTHER

NAME ____________________

OCCUPATION ____________________

PLACE OF EMPLOYMENT ____________________

WORK # ____________ CELL # ____________

LIST TWO PEOPLE TO BE CONTACTED IN THE EVENT OF AN EMERGENCY IF PARENT/GUARDIAN CANNOT BE CONTACTED

Name	Name
Street Address	Street Address
City Home Phone	City Home Phone
State Zip Code	State Zip Code
Relationship to Child	Relationship to Child
Cell phone Work Phone	Cell phone Work Phone

Physician	**Dentist**
Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone

A roster is furnished to families of the preschool program, if requested.

Would you like your families information, including parent/s names and phone number/s to be included in the school roster? Yes ________ No ________

Please list your child's name as you would like it to appear in the Pre-K roster....

Student	Parent's Names	Number
____________	____________	____________
	____________	____________