

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

Child's Name ( <i>print or type</i> )	Date of Birth
<b>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):</b>	
<b>Section A- EXAMINATION</b>	
√ 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>	
<input type="checkbox"/> 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 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Weight _____	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	
<b>Signature of Examining Health Care Practitioner</b>	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.**

<b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b>	
<b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b>	
Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
<b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b>	Initials of Examining Health Care Practitioner
<input type="checkbox"/> 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>	Date
<b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b>	Signature of Parent
<input type="checkbox"/> 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):	
	Date