

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
 Child Care Centers and Type A Homes

| | |
|------------------------------|---------------|
| Child's Name (print or Type) | Date of Birth |
|------------------------------|---------------|

This is to Certify that I have examined this child and their health records and found that:

- 1) This child has had the immunizations required by section 3313.671 of the revised Code for admission to school or has had the immunizations recommended by the state department of health according to the child's age, or is to be exempted from these requirements for medical reasons. Please note exemptions: _____

| Immunizations (*) (Enter month, day and year) | | | | | |
|--|--------|--------|--------|--------|--------|
| Vaccine | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
| Diphtheria, Tetanus, Pertussis (DtaP) | | | | | |
| Hepatitis B (Hep B) | | | | | |
| Haemophilus Influenza type b (HIB) | | | | | |
| Measles, Mumps, Rubella (MMR) | | | | | |
| Inactive Polio | | | | | |
| Varicella (Chicken Pox) | | | | | |
| Influenza | | | | | |
| Pneumococcal Conjugate (PCV) | | | | | |

* The immunizations above are recommended immunizations. Please consult your child's physician for more information.

- 2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.
- 3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) _____

Recommended Assessments/Screenings:

Vision: Yes No Date: _____ Hearing: Yes No Date: _____
 Dental: Yes No Date: _____ Lead: Yes No Date: _____
 BMI: Yes No Date: _____ Other: _____

| | |
|---|---------------------|
| Signature of examining Physician / Certified Nurse Practitioner | Date of Examination |
|---|---------------------|

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility.

| | |
|--|----------------------------|
| Name of Physician / Certified Nurse Practitioner | Telephone Number () |
| Street Address | |
| City, State and Zip Code | |