

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

Child's Name ( <i>print or type</i> )	Date of Birth
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**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 _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Notes:

<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.**

**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