

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 _____  | Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| BMI _____   | Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No     |
|   | Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No       |
|   | Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Notes:  | 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>  | <b>Initials of Examining Health Care Practitioner</b> |
| <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>   | <b>Signature of Parent</b>                            |
| <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): |   |
|  |   |