

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

Child's Name (<i>print or type</i>)	Date of Birth																					
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 (<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 <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">Height _____</td> <td style="width: 15%;">Vision _____</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 15%;">Lead _____</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> </tr> <tr> <td>Weight _____</td> <td>Hearing _____</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Hemoglobin _____</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>BMI _____</td> <td>Dental _____</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Other: _____</td> <td colspan="2"></td> </tr> </table>		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: _____		
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Notes:																						
Signature of Examining Health Care Practitioner	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: <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>	Initials of Examining Health Care Practitioner Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): <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):	Signature of Parent Date