

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

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|---------------------------------------|---------------|
| Child's Name (<i>print or type</i>) | Date of Birth |
|---------------------------------------|---------------|

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

| Recommended Immunizations (<i>enter month, day, and year</i>) | | | | | |
|--|--------|--------|--------|--------|--------|
| Vaccines | 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) | | | | | |
| Inactivated Polio | | | | | |
| Varicella (chicken pox) | | | | | |
| Influenza | | | | | |
| Pneumococcal Conjugate (PCV) | | | | | |
| Rotavirus | | | | | |
| Hepatitis A | | | | | |
| Other | | | | | |

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

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

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|--|---------------------|
| Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse | 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 center or type A home.

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| Name of Physician /Physician's Assistant/Advanced Practice Nurse | Telephone Number |
| Street Address | |
| City, State and Zip Code | |

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.