

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

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

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.

List any limitations or health conditions for this child (including allergies, daily medication, 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/Physician's Assistant/Advanced Practice Nurse	Date of Examination
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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.

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.