Ohio Department of Job and Family Services

# CHILD MEDICAL STATEMENT FOR CHILD CARE

| Child's Name *(print or type)* | Date of Birth |
|---|---|
| | |

☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

☐ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

| Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner | Date of Examination |
|---|---|
| | |
| **Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner** | **Telephone Number** |
| | |
| **Street Address** | |
| | |
| **City, State and Zip Code** | |
| | |

*ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS*

Exceptions to Immunization requirements pursuant to 5104.014 ORC *(please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent)*.

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

| Signature of Parent | Date of Signature |
|---|---|
| | |

**Optional**
**Recommended Assessments/Screenings**

| | | | |
|---|---|---|---|
| Vision | ☐ Yes ☐ No | Lead | ☐ Yes ☐ No |
| Hearing | ☐ Yes ☐ No | Hemoglobin | ☐ Yes ☐ No |
| Dental | ☐ Yes ☐ No | Other | |

| **Measurements** | | **Notes** |
|---|---|---|
| Height | | |
| Weight | | |
| BMI | | |