

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                 |
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| 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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |
| <input checked="" type="checkbox"/> The above named child has been examined.                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |
| <input checked="" type="checkbox"/> 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).                                                                                                                                                                                                                                                                                                      |                                 |
| <input checked="" type="checkbox"/> The above named child does not have allergies OR is allergic to the following ( <i>please list in space below</i> ):<br><div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>                                                                                                                                                                                                                                                                     |                                 |
| <i>Check below, if applicable:</i><br><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<br>Height _____ Vision _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Weight _____ Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No<br>BMI _____ Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Other: _____<br>Notes: |                                 |
| <b>Signature of Examining Health Care Practitioner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Date of Examination</b>      |
| <b>Name of Examining Health Care Practitioner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Telephone Number</b>         |
| <b>Street Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>City, State and Zip Code</b> |

**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><br><b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b><br>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><br><input type="checkbox"/> The above named child has been immunized against the diseases listed above.<br><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>   | <b>Initials of Examining Health Care Practitioner</b><br><br><div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> |
|                                                                                                                                                                                                                                                                                                                                                                  | <b>Date</b>                                                                                                                              |
| <b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b><br><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):                                                     | <b>Signature of Parent</b><br><br><div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>                            |
|                                                                                                                                                                                                                                                                                                                                                                  | <b>Date</b>                                                                                                                              |