Reset Form

Ohio Department of Job and Family Services

# CHILD MEDICAL STATEMENT

**For Child Care Centers and Type A Family Child Care Homes**

| Child's Name *(print or type)* | 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: _____

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

**Recommended Immunizations (***enter month, day, and year***)**

| 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: _____

| 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.**

| 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.