

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

|                                                                                                                                                                              |                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| Child's Name ( <i>print or type</i> )                                                                                                                                        | Date of Birth              |
| <input type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. |                            |
| <b>Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner</b>                                                           | <b>Date of Examination</b> |
| 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**

|                                                                                                                                                                                                                           | <b>PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES</b><br><i>check all that apply for each disease</i> |                            |                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------|
| Diseases for Immunization                                                                                                                                                                                                 | Immunized                                                                                                                                              | In Process of Immunization | Medically Contraindicated/<br>Not Age Appropriate        |
| Chicken pox                                                                                                                                                                                                               | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Diphtheria                                                                                                                                                                                                                | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Haemophilus influenzae type b                                                                                                                                                                                             | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Hepatitis A                                                                                                                                                                                                               | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Hepatitis B                                                                                                                                                                                                               | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Influenza<br><input type="checkbox"/> Seasonal Vaccine Not Available                                                                                                                                                      | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Measles                                                                                                                                                                                                                   | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Mumps                                                                                                                                                                                                                     | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Pertussis                                                                                                                                                                                                                 | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Pneumococcal disease                                                                                                                                                                                                      | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Poliomyelitis                                                                                                                                                                                                             | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Rotavirus                                                                                                                                                                                                                 | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Rubella                                                                                                                                                                                                                   | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| Tetanus                                                                                                                                                                                                                   | <input type="checkbox"/>                                                                                                                               | <input type="checkbox"/>   | <input type="checkbox"/>                                 |
| <input type="checkbox"/> I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below. |                                                                                                                                                        |                            |                                                          |
| Signature of Parent                                                                                                                                                                                                       | Date of Signature                                                                                                                                      |                            |                                                          |
| <b>Recommended Assessments/Screenings</b>                                                                                                                                                                                 |                                                                                                                                                        |                            |                                                          |
| Vision                                                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               | Lead                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing                                                                                                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               | Hemoglobin                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental                                                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               | Other                      |                                                          |
| <b>Measurements:</b>                                                                                                                                                                                                      |                                                                                                                                                        | <b>Notes:</b>              |                                                          |
| Height                                                                                                                                                                                                                    |                                                                                                                                                        |                            |                                                          |
| Weight                                                                                                                                                                                                                    |                                                                                                                                                        |                            |                                                          |
| BMI                                                                                                                                                                                                                       |                                                                                                                                                        |                            |                                                          |