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

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) _____

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