Ohio Department of Job and Family Services

**CHILD MEDICAL STATEMENT FOR CHILD CARE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child’s Name *(print or type*) | | | Date of Birth | |
| **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):** | | | | |
| **Section A- EXAMINATION** | | | | |
| **√** The above named child has been examined. | | | | |
| **√** 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). | | | | |
| **√** The above named child does not have allergies OR is allergic to the following (*please list in space below)*: | | | | |
|  |  | | |  |
| *Check below, if applicable:*  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  Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision \_\_\_\_\_\_\_\_\_\_\_\_ Yes No Lead \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No  Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing \_\_\_\_\_\_\_\_\_\_\_ Yes No Hemoglobin \_\_\_\_\_\_\_\_\_\_\_ Yes No BMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental \_\_\_\_\_\_\_\_\_\_\_\_ Yes No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notes: | | | | |
| **Signature of Examining Health Care Practitioner** | | | Date of Examination | |
| Name of Examining Health Care Practitioner | | | Telephone Number | |
| Street Address | | City, State and Zip Code | | |

***ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.***

|  |  |
| --- | --- |
| **IMMUNIZATION(*Complete ONLY ONE SECTION below)***  ***Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:***  Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus. | |
| **Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:**  The above named child has been immunized against the diseases listed above.  *If an immunization is medically contraindicated or not medically appropriate for the child’s age, note any exceptions by listing the specific immunization(s):* | **Initials of Examining Health Care Practitioner** |
| Date |
| **Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):**  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): | **Signature of Parent** |
| Date |

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