Ohio Department of Job and Family Services

**CHILD MEDICAL STATEMENT FOR CHILD CARE**

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| --- | --- |
| 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.***

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| **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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