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 mediation, 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: Dental: Yes No Date: BMI: Yes No Date:						
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			I			
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.