

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT**  
 For Child Care Centers and Type A Family Child Care Homes

|                                       |               |
|---------------------------------------|---------------|
| Child's Name ( <i>print or type</i> ) | 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) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| <b>Immunizations</b> ( <i>enter month, day, and year</i> ) |        |        |        |        |        |
|--|--------|--------|--------|--------|--------|
| 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