

Reset Form

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (print or type)		Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.		
<input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner		Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State and Zip Code		

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature
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Optional Recommended Assessments/Screenings

Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements		Notes	
Height			
Weight			
BMI			