Office of Early Learning and School Readiness

Child Medical Statement

Childs' Name_____ Date of Birth_____

Height _____ Weight_____

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	Please circle one	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please circle one	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one) Address : Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/Screenings	Completed Please circle one		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

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 Center for Disease Control and Prevention and the Ohio Department of Health					