Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT
Child Care Centers and Type A Homes

This is to certify that I have examined this child and their health records and found that: 1) This child has had the immunizations required by section 3313.671 of the Revised Code I admission to school, or has had the immunizations recommended by the state department health according to the child's age, or is to be exempted from these requirements for med reasons. Please note exemptions: Immunizations(*) (enter month, day, and year)	Child's Name (print or type)				Date of Birth	
Vaccine	This child has l admission to so health according	nad the immur hool, or has h g to the child'	nizations requir ad the immuni s age, or is to l	red by section 3 zations recommon be exempted from	3313.671 of the nended by the som these require	e Revised Code for state department of rements for medica
Diphtheria, Tetanus, Pertussis (DTaP) Hepatitis B (Hep B) Haemophilus Influenza type b (HB) Measles, Mumps, Rubella (MMR) Inactivated Polio Varicella (chicken pox) Influenza Pneumococcal Conjugate (PCV) the immunizations above, are recommended immunizations. Please consult your child's physician for more infor 2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care. 3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) **Total Commended Assessments/Screenings:** Vision: Yes No Date: Hearing: Yes No Date: BMI: Yes No Date: Cother: Signature of examining Physician / Certified Nurse Practitioner O Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more live months prior to the date of admission to the child care facility. Name of Physician / Certified Nurse Practitioner Telephone Number (Immunizations(*) (enter	month, day,	and year)			
Hepatitis B (Hep B)	Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Haemophilus Influenza type b (HIB) Measles, Mumps, Rubella (MMR) Inactivated Polio Varicella (chicken pox) Influenza Pneumococcal Conjugate (PCV) The immunizations above, are recommended immunizations. Please consult your child's physician for more informs in suitable condition for participation in group care. 3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) The immunizations above, are recommended immunizations. Please consult your child's physician for more information in group care. 3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) The immunication of the later of this examination, this child is in suitable condition for participation in group care. The immunication of the later of this examination, this child is in suitable condition for participation in group care. The immunication of the later of this examination of the later of this examination be given no more than the semination of the child care facility. The participation of the later of the						
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Inactivated Polio	-					
Varicella (chicken pox) Influenza Pneumococcal Conjugate (PCV) ne immunizations above, are recommended immunizations. Please consult your child's physician for more infor 2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care. 3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) Destruction Date:						
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Description Date:	Influenza					
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3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions)	2) Based upon medical h	istory and phys	sical condition at	the time of this		
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Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more we months prior to the date of admission to the child care facility. Name of Physician /Certified Nurse Practitioner Telephone Number	Vision: Yes \square No \square Dental: Yes \square No \square 1	Date: Date:		Lead:	Yes □ No □	
ve months prior to the date of admission to the child care facility. Name of Physician / Certified Nurse Practitioner Telephone Number ()	Signature of examining Physician / Certif	ied Nurse Practitioner	r		Date of Examin	nation
	ve months prior to the date of	of admission to		-		
Street Address	Name of Physician /Certified Nurse Pract	iuoner			1	ncı
	Street Address				-	