Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Pediatric Associates of Mt. Carmel, Inc	(513) 752-3650

Street Address
4371 Ferguson Drive

City, State and Zip Code
Cincinnati, OH 45245

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

	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES *check all that apply for each disease*		
Diseases for Immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
Chicken pox	☐	☐	☐
Diphtheria	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
Measles	☐	☐	☐
Mumps	☐	☐	☐
Pertussis	☐	☐	☐
Pneumococcal disease	☐	☐	☐
Poliomyelitis	☐	☐	☐
Rotavirus	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature

Recommended Assessments/Screenings			
Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements:		**Notes:**
Height		
Weight		
BMI		