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 and 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
Street Address	
City, State and Zip Code	

Diseases for Immunization	**Physician /Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes** *check all that apply*			**Parent Declined** *Check any that have been declined and sign below*
	Immunization In Process or Complete	**Medically Contraindicated**	**Not Medically Appropriate for Age of Child**	
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	☐	☐	☐	☐

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

☐ I have declined to have my child immunized against one or more of the disease listed above for reasons of conscience, including religious convictions.

Signature of Parent