Ohio | Department of Education

Office of Early Learning and School Readiness

# Child Medical Statement

Revised 3/12/2018

**This form meets Ohio Administrative Code. Programs may use this form or build their own.**

## Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

| Immunizations: | | Exempt from Immunization: | |
|---|---|---|---|
| Complete for Age | ○ Yes ○ No | Religious Conviction | ○ Yes ○ No |
| In Process | ○ Yes ○ No | Health | ○ Yes ○ No |
| | | Other | _____ |

Limitations or health conditions, including allergies, medications, and dietary restrictions.

## Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

**Check box of examining medical professional:**

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

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

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.