PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD

CHILD MEDICAL STATEMENT #4

2015 - 2016

TO BE COMPLETED BY A PHYSICIAN

Child's Name: _____ Date of Birth: _____

Male:_____ Female: _____

Height:_____ Weight: _____

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

Immunizations	
Complete for age	Yes__ No__
In Process	Yes__No__

Exempt from Immunizations	
Religious conviction	Yes___ No___
Health Concern	Yes___ No___
Other	

Parent Signature: _____ *Date:* _____

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

Physician_____ Physicians Assistant_____

Signature: _____ *Advance Practice Nurse_____ (please indicate one)*

Address: _____ *Phone:* _____

Date of Exam: _____

Assesments/Screenings			Date Completed	Reason not completed
Vision	Yes____	No ____	_____	_____
Hearing	Yes____	No ____	_____	_____
Dental	Yes____	No ____	_____	_____
Lead	Yes____	No ____	_____	_____
Hemoglobin	Yes____	No ____	_____	_____

* For additional information please refer to the Ohio Administrative Code 51012:2-12-37 for Child Care, Head Start, Pre-School and the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Click on "I" and then "Immunization" and the "Required Vaccines for Childcare and School"). These documents list required and recommended immunizations and indicate exemptions to immunizations.

* Please contact the Ohio Department of Health Immunization Program at (800)282-0546 or (614)466-4643 with questions or concerns.