



CHILD MEDICAL STATEMENT

As per the Ohio Department of Education Office of Early Learning, students attending Early Childhood Programs Birth-5 years old must have an updated physical and immunization record signed by a physician each year.

Section 1 - Child Medical Information

Child's Name _____ Parent/Guardian Name _____

Date of Birth _____ Height _____ Weight _____ BMI _____

Age at time of Physical _____

Immunizations*:	Exemption from Immunization:
Complete for Age <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical** <input type="checkbox"/> Yes <input type="checkbox"/> No
In Process <input type="checkbox"/> Yes <input type="checkbox"/> No	**please note that additional medical exemption form must accompany this status

***PLEASE ATTACH A COPY OF MOST RECENT IMMUNIZATION RECORD**

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

Additional Screenings Recommended:

____ VISION ____ HEARING ____ DENTAL ____ LEAD ____ BMI ____ OTHER (please specify): _____

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Phone Number _____

Provider Address _____ Provider City _____ Provider State/Zip _____

Check box examining medical professional:

- Physician Physician's Assistant Advanced Practice Nurse

This child has been examined, immunizations status recorded and is in suitable condition to participate in early childhood group care settings.

Signature of Medical Professional _____ Date of Exam _____