

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	<input type="radio"/> Yes	<input type="radio"/> No
In Process	<input type="radio"/> Yes	<input type="radio"/> 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.