



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 \_\_\_\_\_

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, and Health, each with Yes/No radio buttons.

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

Large empty rectangular box for providing health condition details.

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's Assistant
Advanced Practice 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.