



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

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, Health, and Other.

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

Large empty rectangular box for notes or conditions.

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.

### Section III - Child Vision and Hearing Screening

#### Vision

Rt. Eye  Pass  Fail

Lt. Eye  Pass  Fail

Method used for screening \_\_\_\_\_

#### Hearing

Rt. Ear  Pass  Fail

Lt. Ear  Pass  Fail

Method used for screening \_\_\_\_\_