

**CHILD MEDICAL STATEMENT FOR PRESCHOOL**

Child's Name (<i>print or type</i>)		Date of Birth
<input type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State and Zip Code		

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Diseases for Immunization	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES <i>check all that apply for each disease</i>		
	Immunized	In Process of Immunization	Medically Contraindicated/ Not Age Appropriate
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenzae type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza <input type="checkbox"/> Seasonal Vaccine Not Available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.			
Signature of Parent		Date of Signature	
Recommended Assessments/Screenings			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements:		Notes:	
Height			
Weight			
BMI			