



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