Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
Child Care Centers and Type A Homes

Child's Name (print or type)	Date of Birth
Braylen Morgan	12-3-2008

This is to certify that I have examined this child and their health records and found that:

1) This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations recommended by the state department of health according to the child's age, or is to be exempted from these requirements for medical reasons. Please note exemptions: _____

Immunizations(*) (enter month, day, and year)					
Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)	See attached form				
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					

* The immunizations above, are recommended immunizations. Please consult your child's physician for more information.

2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.

3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) _____

Recommended Assessments/Screenings:

Vision: Yes ☐ No ☐ Date: _____
Dental: Yes ☐ No ☐ Date: _____
BMI: Yes ☒ No ☐ Date: 7-21-10 (18)

Hearing: Yes ☐ No ☐ Date: _____
Lead: Yes ☒ No ☐ Date: 7-21-10 (3)
Other: _____

Signature of examining Physician / Certified Nurse Practitioner	Date of Examination
R Suse MD / P Ferrantin RN	7-21-10

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility.

Name of Physician /Certified Nurse Practitioner	Telephone Number
Robert Suse MD	( )
Street Address	NATIONWIDE CHILDREN'S HOSPITAL PRIMARY CARE CENTERS-LINDEN 1390 CLEVELAND AVENUE
City, State and Zip Code	COLUMBUS, OHIO 43211 614-355-9300 FAX: 614-355-9310

Patient Information

Patient Name	Sex	DOB
Morgan, Braylen Kortez (1679524)	Male	12/3/2008

Immunizations as of 8/25/2010

DTaP	7/21/2010 (19 mos)
DTaP/HIB/IPV	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
HIB	7/21/2010 (19 mos)
Hepatitis A	7/21/2010 (19 mos)
Hepatitis B	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
MMR	7/21/2010 (19 mos)
PNEUMOCOCCAL (PREVNAR 13)	7/21/2010 (19 mos)
Pneumococcal (Prevnar)	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
ROTATEQ	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
Varicella	7/21/2010 (19 mos)

Allergies as of 8/25/2010

Date Reviewed: **8/2/2010**

No Known Allergies

NATIONWIDE CHILDREN'S HOSPITAL
PRIMARY CARE CENTERS-LINDEN
1390 CLEVELAND AVENUE
COLUMBUS, OHIO 43211
614-355-9300 FAX: 614-355-9310

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
Child Care Centers and Type A Homes

Child's Name (print or type)	Date of Birth
Morgan, Braylen K	12-3-08

This is to certify that I have examined this child and their health records and found that:

1) This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations recommended by the state department of health according to the child's age, or is to be exempted from these requirements for medical reasons. Please note exemptions: _____

Immunizations(*) (enter month, day, and year)					
Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)	See attached				
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					

* The immunizations above, are recommended immunizations. Please consult your child's physician for more information.

2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.

3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) None

Recommended Assessments/Screenings:

Vision: Yes ☐ No ☑ Date: _____
Dental: Yes ☐ No ☑ Date: _____
BMI: Yes ☐ No ☑ Date: _____
Hearing: Yes ☐ No ☑ Date: _____
Lead: Yes ☐ No ☑ Date: _____
Other: _____

Signature of Examining Physician / Certified Nurse Practitioner	Date of Examination
J Kapeches MD / D Johnson	6-11-09

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility.

Name of Physician / Certified Nurse Practitioner	Telephone Number
	( )
Street Address	NATIONWIDE CHILDREN'S HOSPITAL PRIMARY CARE CENTER - LINDEN 1300 CLEVELAND AVE.
City, State and Zip Code	COLUMBUS, OH 43211 PHONE 614-355-9300 FAX 614-355-9310

JFS 01305 (Rev. 9/2006)

NATIONWIDE CHILDREN'S HOSPITAL™

Patient Demographics

Address	Phone
2255 HANNA DRIVE COLUMBUS OH 43211	614-478-7822 (Home) 614-208-4982 (Work)

Patient Information

Patient Name	Sex	DOB
Morgan, Braylen Kortez (1679524)	Male	12/3/2008

Immunizations as of 10/1/2009

DTaP/HIB/IPV	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
Hepatitis B	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
Pneumococcal (Prevnar)	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)
ROTATEQ	6/11/2009 (6 mos), 4/23/2009 (4 mos), 2/16/2009 (2 mos)

Allergies as of 10/1/2009 Date Reviewed: **9/18/2009**

No Known Allergies

NATIONWIDE CHILDREN'S HOSPITAL
PRIMARY CARE CENTER - LINDEN
1390 CLEVELAND AVE.
COLUMBUS, OH 43211
PHONE 614-355-9300 FAX 614-355-9310

Need Fax #
Liden Close to home
in the Cota Building
355-9310
Fax #

Immunizations Records

This Fax is for the administrative staff of the patient of Brayden Morgan. This child needs medical records, for Coleeta Daycare. Please fax back filled out: Ohio Department Of Child and Family Services Medical Statement. Thank you for your time! If you cannot sign of on the Job And Family Services Medical Statement, please call or fax us back the reason it cannot be completed.

Parents Signature: Jaqueshea Morgan

Fax to:
(Director) Katie Sheldon
fax number: 614-310-0469
Phone number: 614-310-0430 Ext. 2013
permission

Thank- you,