Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth
Edward Butler Jr	12/30/06

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily mediation, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year*)

Vaccines	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)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____ Hearing: ☐ Yes ☐ No Date: _____

Dental: ☐ Yes ☐ No Date: _____ Lead: ☐ Yes ☐ No Date: _____

BMI: ☐ Yes ☐ No Date: _____ Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
Cheryl Pippin MD	7/8/10

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 center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Pippin	
Street Address	NATIONWIDE CHILDREN'S HOSPITAL PRIMARY CARE CENTER-NORTHLAND 4560 MORSE CENTER ROAD
City, State and Zip Code	COLUMBUS, OHIO 43229

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

Patient Name	Sex	DOB
Butler, Edward (1706573)	Male	12/30/2006

Immunizations as of 7/8/2010

DTaP	6/24/2008 (17 mos), 7/3/2007 (6 mos), 4/30/2007 (4 mos), 3/6/2007 (2 mos)
H1N1 INFLUENZA VACCINE 6-35 MO	12/7/2009 (2 yrs)
HIB	12/7/2009 (2 yrs), 7/3/2007 (6 mos), 4/30/2007 (4 mos), 3/6/2007 (2 mos)
Hepatitis A	7/8/2010 (3 yrs), 6/18/2009 (2 yrs)
Hepatitis B	10/9/2007 (9 mos), 3/6/2007 (2 mos), 1/12/2007 (13 days)
IPV	6/24/2008 (17 mos), 4/30/2007 (4 mos), 3/6/2007 (2 mos)
Influenza (nasal)	12/7/2009 (2 yrs)
MMR	2/7/2008 (13 mos)
PNEUMOCOCCAL (PREVNAR 13)	7/8/2010 (3 yrs)
Pneumococcal (Prevnar)	2/7/2008 (13 mos), 7/3/2007 (6 mos), 4/30/2007 (4 mos), 3/6/2007 (2 mos)
Varicella	2/7/2008 (13 mos)

Allergies as of 7/8/2010

Date Reviewed: **7/8/2010**

No Known Allergies