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 ______

Immunizations:		**Exempt from Immunization:**	
Complete for Age	◯ Yes ◯ No	Religious Conviction	◯ Yes ◯ No
In Process	◯ Yes ◯ No	Health	◯ Yes ◯ 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.

Child's Name:______________________________________ Date of Birth____________________

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments / Screenings	Completed		Date Completed	Health professional decision	Religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

Report of Exam: A check mark denotes within normal limits

Height	Weight	Blood Pressure	Extremities
Head	Eyes	Ears	Nose
Throat / Mouth	Neck	Chest	Lungs
Heart	Abdomen	Back	Rectum
Reflexes	Muscle Tone	Skin	Genitalia
Fine Motor Skills	Gross Motor Skills	Communication Skills	Social-Emotional - Behavior

List Childhood Diseases / Diagnosis:____

Child's Chronic Illness / Hospitalizations:____

Does the child wear glasses: Yes No

Can the child full participate in school activities: Yes No

Does the child have playground restrictions: Yes No If yes, please explain____________________

Other Relevant medical information____