

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		Date of Birth
✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. ✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered 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

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).			
<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. Please note disease above and sign.			
Signature of Parent			Date of Signature
Optional 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			

Ohio Department of Job and Family Services
**REQUEST FOR ADMINISTRATION OF MEDICATION
 FOR CHILD CARE**

Box 1	The following section must always be completed by the parent/guardian.	
<p>Check all that apply and complete all of the information.</p> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Prescription Medication</div> <div><input type="checkbox"/> Nonprescription Medication</div> <div><input type="checkbox"/> Food Supplement</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Topical Product or Lotion</div> <div><input type="checkbox"/> Refrigeration Required</div> <div><input type="checkbox"/> Modified Diet</div> </div>		
Name of Child		Date of Birth
Name of Medication		Exact Dosage
To be administered at the following times		For the following period of time
<input type="checkbox"/> I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).		
Signature of Parent/Guardian		Date
Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.	
<ol style="list-style-type: none"> 1. The medication contains codeine or aspirin. 2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions). 3. It is a sample medication without a prescription label. 4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period. 5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use. 		
Name of child		Name of medication, vitamin, diet, supplement
Dosage		Possible side effects to watch for are
Expiration date (May not exceed twelve months from the date of this request for medications of food supplements).		
Instructions		
This child is under my care and should receive the above medication as written. Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant		
Date of signature		Phone number
Name of child		Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

