Fairview Park Early Education Center

CHILD MEDICAL STATEMENT

Child's Name_____ Date of Birth_____

Height_____ Weight_____

This is to certify the following:	Please circle one
I have examined this child and found he or she is in suitable condition to participate in group care.	Yes No
Limitations or health conditions including allergies, medications, dietary restrictions:	Yes No
The child has had the age appropriate immunizations recommended by the Ohio Department of Health. If exempt from immunizations, please state the reason (religious, personal, health concern, etc.):	Yes No

Please enter the child's immunizations records below or attached a printed record of the immunizations to this medical statement.

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)					
Haemophilius Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatatis A					
Other					
The immunizations above are recommended by the center 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
Print Name of Physician/Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	