Child Medical Statement for Child Care

Child's Name (print or type)	Date of Birth

Please check the box for which well-check this visit is for:
☐1mo ☐2mo ☐3mo ☐4mo ☐6mo ☐9mo ☐12mo ☐15mo ☐18mo ☐24mo ☐30mo ☐3yr ☐4yr ☐5yr

- ✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for the 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).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Is the child up-to-date on a schedule of age appropriate preventative and primary medical care based on well-child visits as prescribed by the EPSDT program of the Medicaid Agency of Ohio? (www.medicaid.gov)

☐ YES ☐ NO

If no, please list the screenings or immunizations that need to be completed for the child to be considered up-to-date:

Please select diagnosed chronic conditions
- ☐ Asthma
- ☐ Seizures
- ☐ Diabetes
- ☐ Autism Spectrum Disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Life threatening allergies
- ☐ Blood lead levels >5 µg/dL
- ☐ Vision problems
- ☐ Hearing problems

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 disease 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).

☐ I have declined to have my child immunized against one or more of the disease required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Hearing and Vision Screening
Hearing completed today: ☐ PASS ☐ REFER If not today, last date completed and result: ____________________
Vision completed today: ☐ PASS ☐ REFER If not today, last date completed and result: ____________________

Dental
General dental assessment completed: ☐ Yes ☐ No Further assessment recommended: ☐ Yes ☐ No

Measurements
Height: ______________________ Weight: ______________________ Head Circumference: ______________________

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