

### Child Medical Statement for Child Care

<b>Child's Name (print or type)</b>	<b>Date of Birth</b>
<b>Please check the box for which well-check this visit is for:</b> <input type="checkbox"/> 1mo <input type="checkbox"/> 2mo <input type="checkbox"/> 4mo <input type="checkbox"/> 6mo <input type="checkbox"/> 9mo <input type="checkbox"/> 12mo <input type="checkbox"/> 15mo <input type="checkbox"/> 18mo <input type="checkbox"/> 24mo <input type="checkbox"/> 30mo <input type="checkbox"/> 3yr <input type="checkbox"/> 4yr <input type="checkbox"/> 5yr	
<ul style="list-style-type: none"> <li>✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for the participation in group care.</li> <li>✓ 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).</li> </ul>	

<b>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</b> 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? ( <a href="http://www.medicaid.gov">www.medicaid.gov</a> ) <div style="text-align: center;"> <input type="checkbox"/> YES      <input type="checkbox"/> NO       </div> <p><small>If no, please list the screenings or immunizations that need to be completed for the child to be considered up-to-date:</small></p>	<b>Please select diagnosed chronic conditions</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Vision problems <input type="checkbox"/> Seizures <input type="checkbox"/> Hearing problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Life threatening allergies <input type="checkbox"/> Blood lead levels >5 µg/dL
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**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS**

<b>Exceptions to Immunization requirements pursuant to 5104.014 ORC</b> (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).	
<input type="checkbox"/> 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

<b>Hearing and Vision Screening</b>	
Hearing completed today: <input type="checkbox"/> PASS <input type="checkbox"/> REFER	If not today, last date completed and result: _____
Vision completed today: <input type="checkbox"/> PASS <input type="checkbox"/> REFER	If not today, last date completed and result: _____
<b>Dental</b>	
Dental Screen completed:    Yes <input type="checkbox"/> No <input type="checkbox"/>	Further assessment recommended:    Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Measurements</b>	
Height: _____	Weight: _____      Head Circumference: _____

<b>Signature</b> 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	