

## Child Medical Statement

Childs' Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Visual Acuity: R \_\_\_\_\_ L \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

Limitations or health condition (including allergies, medications, dietary restrictions)


Immunizations	Please circle one	
	Complete for age	Yes
In Process	Yes	No

Exempt from Immunizations	Please circle one	
	Religious conviction	Yes
Health concern	Yes	No
Other:		

Please attach a copy of current immunizations

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one)	Date of exam
Address :	
Phone:	

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 Please circle one		Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No		
Hearing	Yes	No		
Dental	Yes	No		
Lead	Yes	No		
Hemoglobin	Yes	No		

ODH requires information regarding the Lead and Hemoglobin. If no is circled, please fill in the reason, such as not indicated. Thank you.