Annual Child Medical Statement

Columbus School for Girls

Summer Programs

614-252-0781 ext. 435 Fax: 614.252.0571 Attn: Rachel Barends, Director

Student Name:_____ **Birth Date:**_____

This is to certify all of the following:

1) I have examined this child and found that he or she is in suitable condition for participation in group care.

2) The child has had the age appropriate immunizations recommended by the Ohio Department of Health.

3) My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:

List any limitations of health conditions for this child (including allergies, daily medications, or dietary restrictions).

Recommended Immunizations (enter month, day, and year)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diptheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Pneumococcal Conjugate (PCV)					
Influenza					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers 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
Name of Physician/Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State, Zip Code	

Ohio Administrative Code rules 5101-2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility. **This form is to be completed by your child's physician.**