THIS FORM MUST BE COMPLETED WITHIN 30 DAYS OF ENROLLMENT AND UPDATED ANNUALLY, 13 MONTHS FROM LAST PHYSICAL

DUE:

CHILD MEDICAL STATEMENT
SHEFFIELD-SHEFFIELD LAKE CITY SCHOOLS PRESCHOOL PROGRAM

Child's Name	Date of Birth
Immunizations:	
Complete for Age ☐ yes ☐ no	In Process ☐ yes ☐ no
Exempt from Immunizations:	
Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases 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 diseases required by 5104.014 of the Ohio Revised Code. Please note diseases above. Sign below.	
Parent Signature	Date
ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS	
Limitations or health conditions, including allergies, medications, and dietary restrictions	

Recommended Assessments/Screenings (optional)			**Measurements**
Vision ☐ yes ☐ no	Dental ☐ yes ☐ no	Lead ☐ yes ☐ no	Height
Hearing ☐ yes ☐ no	Hemoglobin ☐ yes ☐ no	Other	Weight
			BMI

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

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination
Name of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	