

**OHIO DEPARTMENT OF EDUCATION  
DIVISION OF EARLY CHILDHOOD EDUCATION**

**CHILD'S MEDICAL STATEMENT**

THIS IS TO CERTIFY THAT I HAVE EXAMINED (CHILD'S NAME) \_\_\_\_\_

1. HAS HAD THE IMMUNIZATIONS REQUIRED BY SECTION 3313.671 OF THE OHIO REVISED CODE FOR ADMISSION TO SCHOOL, OR HAS HAD THE IMMUNIZATIONS REQUIRED BY THE OHIO DEPARTMENT OF HEALTH FOR INFANTS AND TODDLERS, OR \_\_\_\_\_ IS TO BE EXEMPTED FROM THESE REQUIREMENTS FOR MEDICAL OR RELIGIOUS REASONS.

**IMMUNIZATION RECORD:** ENTER MONTH/DAY/YEAR OF EACH IMMUNIZATION. (THIS INFORMATION IS REQUIRED PRIOR TO THE FIRST DAY OF ATTENDANCE.)

DTP	1.	2.	3.	4.	5*	5 <sup>TH</sup> DOSE REQUIRED PRIOR TO KINDERGARTEN
POLIO (IPV/IPV)	1.	2.	3.	4*		4 <sup>TH</sup> DOSE REQUIRED PRIOR TO KINDERGARTEN
MMR*	1.		MEASLES	MUMPS	RUBELLA	2 <sup>ND</sup> DOSE REQUIRED FOR GRADES K-1 & 7-12
HIB	1.					0-14 MONTHS: 3-4 DOES 15-59 MONTHS: 1 DOSE
HEPATITIS B	1.	2.	3.			REQUIRED K-1
VARICELLA **	1					

\* IF MEASLES, MUMPS, RUBELLA NOT GIVEN AS MMR, GIVE DATES FOR EACH IMMUNIZATION.

\*\* RECOMMENDED IF CHILD HAS NOT RECEIVED CHICKEN POX.

2. IS FREE FROM APPARENT COMMUNICABLE DISEASE AND IS IN SUITABLE CONDITION TO ATTEND A PRESCHOOL PROGRAM, BASED ON HIS/HER MEDICAL HISTORY AND PHYSICAL CONDITION AT THE TIME OF THIS EXAMINATION.

PHYSICIAN'S SIGNATURE OR STAMP	DATE:
PHYSICIAN NAME (PRINT)	
PHYSICIAN ADDRESS CITY, STATE, ZIP CODE	
PHYSICIAN PHONE	
PARENT(S)/GUARDIAN NAME	
CHILD'S BIRTHDATE	

A MEDICAL STATEMENT IS REQUIRED ANNUALLY. IT MAY BE COMPLETED ON AN ANNUAL SCHEDULE ACCORDING TO THE INITIAL EXAMINATION DATE OR IT MAY BE COMPLETED ON A SCHEDULE AS REQUIRED BY THE PROGRAM FOR ANNUAL UPDATES. IT MUST BE CURRENT FOR THE CHILD'S ENROLLMENT YEAR (WITHIN THE PAST 12 MONTHS).

ACCORDING TO RULE 3301-37-05A, THE MEDICAL STATEMENT IS REQUIRED NO LATER THAN 30 DAYS AFTER ADMISSION. FOR 3 YEAR OLDS, EXAMINATION SHOULD BE WITHIN 6 MONTHS PRIOR TO ADMISSION. FOR 4 YEAR OLDS, IT SHOULD BE WITHIN 12 MONTHS PRIOR TO ADMISSION.