



CALICO CENTER CHILD MEDICAL STATEMENT

Child's Name _____ Date of Birth _____

Height _____ Weight _____

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

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| Immunizations | Please circle one | |
|------------------|-------------------|----|
| Complete for age | Yes | No |
| In process | Yes | No |

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

This is to certify that I have examined this child and have found that this child is in suitable condition to participate in group care and that this child has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or, has had the immunizations required by the state department of health for infants and toddlers.

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| Signature of examining Physician/Physician Assistant or Advanced Practice Nurse: Address: _____ _____ Phone: _____ | Date of Exam |
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