

Ohio Department of Job and Family Services

CHILD'S HEALTH RECORD

A complete health record is required to be on file in the home of a provider on or before the first day child care is provided. This form shall be reviewed and updated as least once a year.

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|------------------------------|---------------|
| Child's Name (print or type) | Date of Birth |
| Parent's Name | Date of Exam |

| IMMUNIZATIONS (Enter month, day and year) | | | | | |
|--|---------------|---------------|---------------|---------------|---------------|
| VACCINE | DOSE 1 | DOSE 2 | DOSE 3 | DOSE 4 | DOSE 5 |
| Diphtheria, Tetanus, Pertussis (DTP) | | | | | |
| Hepatitis | | | | | |
| Haemophitus b (HIB) | | | | | |
| Measles, Mumps, Rubella (MMR) | | | | | |
| Polio | | | | | |
| Varicella Zoster (Chicken Pox) | | | | | |
| Hepatitis A | | | | | |

Allergies - List all allergies affecting the child and any special precautions or treatments indicated for these allergies: _____

Medications or Food Supplements - List all medications or food supplements currently being administered to the child: _____

Dietary Restrictions - List all modified dietary restrictions affecting the child: _____

Special Needs or Chronic Health Problems - List any special needs or any chronic health problems affecting the child: _____

History of Hospitalizations - List dates of all hospitalizations of the child: _____

Diseases - List all diseases the child has had: _____

Indicate any limitations or modifications of the child's participation in daily child care activities or any special treatments needed: _____

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|----------------------------------|-------------------------------|
| Name of Physician (please print) | Telephone Number |
| Street Address | |
| City, State, and Zip Code | |
| Physician's Signature | Date of Physician's Signature |

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|--------------------|------|
| Parent's Signature | Date |
|--------------------|------|

This form meets the requirements of chapter 5101:2-14 of the Administrative Code.