

Ohio Department of Job and Family Services
EMPLOYEE MEDICAL STATEMENT
FOR CHILD CARE CENTERS AND TYPE A HOMES

The completion of this form is required by Ohio Administrative Code rules 5101:2-12-25 and 5101:2-13-25 that govern the licensing of child care centers and type A homes.

Name of Employee	
Home Address	
First Day of Employment	

My signature below certifies that I examined the above-named person who is found to be:

1. Free of communicable tuberculosis
2. Physically fit for employment in a facility caring for children
3. Immunized against Diphtheria/Tetanus/Pertussis (Tdap) and Measles, Mumps and Rubella (MMR)

Name of Physician or Certified Nurse Practitioner (Please print)	
Street Address:	
City, State, Zip	Phone Number

Signature of Physician or Certified Nurse Practitioner	Date of Examination
--	---------------------

- This employee may be required to be immunized according to the Occupational Safety and Health Enforcement and Administration (OHSEA) requirements regarding hepatitis B vaccinations. Child care employees are at risk of exposure as defined by OHSEA. Declination statements from employees declining the hepatitis B vaccinations and post exposure treatment plans are kept on file at child care facilities and are acceptable forms of compliance with the OHSEA regulations
- The employee may be exempt from the immunization requirements listed in #3 above, for medical reasons upon filing a written request from the physician or certified nurse practitioner.
- The employee may be exempt from the immunization requirements listed in #3 above, for religious reasons upon filing a written request with the child care facility.
- Employee medical examinations must be updated every three years.

Attention Medical Provider!

Federal and State law require that we obtain written documentation of TB Screening Results and Immunization Records for a complete medical statement.

Please provide the information below by using this form or submitting the information in a format that is convenient to you.

Please write legibly!
Thank You!

TB Test Results

Date Administered: _____

Date Read: _____

Results: _____ mm of induration.

Signature: _____

Please mark one:
_____ Negative
_____ Positive

Immunization Record:

Diphtheria/Tetanus/Pertussis (Tdap): _____ / _____ / _____
(date)

Measles, Mumps and Rubella (MMR): _____ / _____ / _____
(date)

Guidance for Immunization Record:

Tdap:

- Per State law, at the time the next booster for tetanus and diphtheria is due, employee must also be immunized against pertussis (Tdap)

MMR:

- Per State law, persons born on or before 12/31/1956 may be exempt from MMR
- A history of measles and mumps **may substitute** for the vaccine.
- A history of rubella disease **shall not** substitute for rubella vaccine. Only laboratory test demonstrating detectable rubella antibodies shall be accepted in lieu of rubella vaccine.