CATHOLIC DIOCESE OF YOUNGSTOWN
Office of Catholic Schools

# CHILD MEDICAL STATEMENT

## Section I - Child Medical Information

**Child's Name** _____ **Date of Birth** _____

**Height** _____ **Weight** _____

**Limitations of health condition (including allergies, medications, dietary restrictions)**

| |
|---|
| |
| |
| |
| |
| |
| |
| |
| |

| **Immunizations** | | |
|---|---|---|
| Complete for age | Yes | No |
| In Process | Yes | No |

| **Exempt from Immunizations** | | |
|---|---|---|
| Religious conviction | Yes | No |
| Medical Reason | Yes | No |

| **Assessments/Screenings** | **Completed** | **Date completed** | **Results** | **Reason not completed** |
|---|---|---|---|---|
| Vision | Yes No | | | |
| Hearing | Yes No | | | |
| Dental | Yes No | | | |
| Lead | Yes No | | | |
| Hemoglobin | Yes No | | | |

**Was a referral made? Yes No Reason:** _____

## Section II - Child Medical Statement Verification

***This child has been examined and is in suitable condition to participate in group care.***

| **Signature of Examiner:** _____ | Check One: | **Date of Exam:** |
|---|---|---|
| Physician/Clinic/Hospital Name:<br>Provider Address:<br>Provider Phone: | ☐ **Physician**<br>☐ **Physician's Assistant**<br>☐ **Advanced Practice Nurse** | |

Rev. 2/17