Ohio Department of Job and Family Services

**EMPLOYEE MEDICAL STATEMENT FOR CHILD CARE**

The physical examination and completion of this form must occur no more than 12 months prior to the *first* day of employment.

|  |  |
| --- | --- |
| Name of Employee | |
| Home Address | |
| City, State, Zip | |
|  | |
| First Day of Employment | |
| To be completed by the Health Care Provider | |
| My signature below certifies that I examined the above-named person who is found to be  D Physically fit for employment in a facility caring for children  D Immunized against Diphtheria/Tetanus/Pertussis (Tdap)  *(All employees must have verification of being immunized against pertussis by January 1, 2018)*  D Immunized against Measles, Mumps and Rubella· (MMR)  *(Except that for a person born on or before December 31, 1956, a history of mumps or measles disease may be substituted for the vaccine. A history of rubella disease shall not be substituted for rubella vaccine. Only a laboratory test demonstrating detectable rubella antibodies shall be accepted in lieu of rubella vaccine).* | |
|  | |
| Name of Health Care Provider\* *(Please Print)* | |
| Street Address | |
| City, State, Zip | Phone Number |
| Signature of Health Care Provider\* | Date of Examination |

\*This form may be signed by a licensed physician, physician's assistant, advanced practice registered nurse, certified midwife or certified nurse practitioner.

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