Reset Form

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:

☐ Physically fit for employment in a facility caring for children

☐ Immunized against Tetanus/Diphtheria/Pertussis (Tdap)

☐ 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).

***This section must be completed if the employee is applying to be an administrator, child care staff member or employee of a child care center.*

☐ **Screened for Tuberculosis (TB)

- *Has the employee resided in a country identified by the world health organization (WHO) as having a high burden of tuberculosis (TB)?* ☐ Yes ☐ No
- *Has the employee arrived in the United States within the five years immediately preceding the date of application for employment?* ☐ Yes ☐ No

Employment Application Date: _____

If the answers to **both questions** above are yes, the individual is required to be tested for TB.

TB Test Date: _____ TB Test Results: ☐ Negative ☐ Positive

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 nurse midwife or certified nurse practitioner.