Ohio | Department of Education

Office of Early Learning and School Readiness

Employee Medical Statement

Revised 6/7/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Medical Provider Information

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ City _____ State _____ Zip _____

Section II - Medical Statement Verification

Employee Name _____

Certify Employee Medical Status:

☐ Free of Communicable Disease

☐ Fit to work with children in the following age groups

- ☐ Infant/Toddler
- ☐ 3 years - 14 years

Check box of examining medical professional:

☐ Physician ☐ Physician Assistant ☐ Advanced Practice Registered Nurse

Signature of Medical Professional _____ Date _____

I verify that the information presented on this form is accurate and complete.

Effective July 1, 2009, staff medical statements must be on file and updated on a regular basis according to program policy.