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Mason, OH. 45040

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**Physical Form**

**2019/2020**

A child will not be admitted to the Parent’s Day Out Program without this completed form, which is valid for one year from date of physician signature.

This is to certify that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Child’s name)

* Has received a physical examination. Date of examination \_\_\_\_\_\_\_\_\_\_\_\_
* Is free from communicable disease and is in suitable condition for participation in a group care.
* Has had age appropriate immunizations recommended by the Ohio Department of Health:

Diphtheria, Tetanus, Pertussis (D TaP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B (Hep B) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Haemophilus Influenza type b (HIB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles, Mumps, Rubella (MMR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inactivated Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal Conjugate (PCV) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rotavirus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Licensed physician signature only)

Physician’s address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_