The Wellington Summer Program

3650 Reed Road
Columbus, OH 43220
Phone: 614/324-8882
Fax: 614/442-3286

Child's Name (please print) _____ Date of Birth _____

Parent's Name _____ Last Office Visit _____

This is to certify that I have examined this child and found that:

1. This child has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the state department of health for infants and toddlers, or is to be exempted from these requirements for medical reasons.

Immunizations (enter month, day and year)

DPT	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	
MMR	/ /	/ /			
Hepatitis B	/ /	/ /	/ /		
HIB-d	/ /	/ /	/ /		
Other (List)	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /

2. Based upon medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition to receive day care.

Name of Physician (please print) _____ Phone Number_____

Street Address _____ City _____ State ____ Zip _____

Physician's Signature _____ Date _____