LEADS Early Head Start HealthChek Form

Fax-740 345 4303

_____ - Month Well Baby/Child Visit Date of Exam: 8-29-16

Child's Name: Willow Tull Age: 2 DOB: 8-28-14

Diet: Breast/Formula _____ (Brand/Type) | Jar/Table Food Amount: _____ Interval: _____

Height: 34" Weight: 28.25# Head Circ: 18 3/4 B/P: _____

SCREENING RESULTS [If applicable for age]:

Vision: _____	**Hearing:** _____	**Immunization:** UTD
Oral Health:	**Blood Lead Screen:** <2	**Hemoglobin:** 12.8

PHYSICAL EXAM RESULTS:

General appearance:	Healthy		
Skin:	Normal	Musculoskeletal:	WNL
Head / Fontanel:		Behavior/Development:	
Eyes:		Chest / Respiratory:	
Ears:		Heart / Cardiovascular:	
Nose:		Genito-Urinary:	
Mouth / Dental:		Spinal examination:	
Neck / Throat:		Neurological:	
Gastrointestinal:		Endocrine:	

ENTERED

ASSESSMENT NOTES:

Healthy

*Next appointment scheduled for _____

*List any limitations or health conditions for this child (including allergies, daily medication, and dietary restrictions):

This is to certify the following:

- **This child is up-to-date according to the Ohio EPSDT schedule for preventative and primary health care.**
- **I have examined this child and found that s/he is in suitable condition for participation in group care.**
- **This child has had the age appropriate immunizations recommended by the Ohio Department of Health.**
- **My office has entered the child's immunizations record above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:**

Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
	8-29-16
Office/Clinic Stamp LICKING MEMORIAL PEDIATRICS 1865 TAMARACK ROAD NEWARK, OHIO 43055	**Telephone Number**

Parent/Guardian MUST return child's completed HealthChek Form & Immunization Record to their Early Head Start Family Service Worker.