

ENTERED  
6/28/17 TTA

**LEADS**



Date of Exam: 4/17/17

Age: DOB: 4/10/2016

Diet: Breast/Formula \_\_\_\_\_ Jar/Table Food Amount: \_\_\_\_\_ Interval: \_\_\_\_\_  
(Brand/Type)

Height: 29.5in Weight: 22lb Head Circ: 18.75in B/P: \_\_\_\_\_

**SCREENING RESULTS (If applicable for age):**

Vision: <i>See ophthalmologist</i>	Hearing: <i>Partial hearing loss</i>	Immunization: <i>Please Attach</i>
Oral Health: <i>M</i>	Blood Lead Screen: <i>NL</i>	Hemoglobin: <i>M</i>

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

Congenital cmo Seizure p/o Conductive Hearing Loss	Next appointment scheduled for <u>7/17/17</u>
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\*List any limitations or health conditions for this child: (including allergies, daily medication, dietary restrictions)

This is to certify the following:

- This child is up-to-date according to the Ohio KPEMT schedule for preventive 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 Breaching Physician/Physician's Assistant/Advanced Practice Nurse \_\_\_\_\_

Mill Valley Pediatrics, Inc.  
Phone# 937-578-1210  
17853 State Route 31  
43040

**Officer/Chief Investigator**

Mill Valley Pediatrics, Inc. 17553 St. Rt. Marysville, OH 937.578.4210

Parent/Guardian **MUST** return child's completed Healthcheck Form & Immunization Record to their Early Head Start Family Service Worker. 201

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