## LEADS HealthChek/Medical Examination

- 1	Bother to LEADS Hand Street/Engly Hand Street				1	
- 1	Return to: LEADS Head Start/Eurly Head Start				f x 1 - f	D.
	161 Wilson Street, Newark, Ohio 43055				Child's Name: All 4nh Clispos: 4-8-13	
	Fara Maring: PH (740)349.7373 Fax (740)345.4303				Child's Name: #	TITUL DOB! O T
1	indsay O'Dell: PH (740)258.6118 Fax (740)345.4303			The state of the s		
	MANADATORY	Date child	Danielan	need follow-	is treatment needed?	is trestment complete?
- 1	EPSDT HealthChek	raceNed screen	Results	up? Y/N		
	Screenings:	phylogopopopop	(D) BENEWING CHIEFE	_ 3 _ 3	YesNoN/A	YesNoN/A
	(f fills floor thinks which a	MARCHAR CONTRACT		STATE OF THE PARTY	For what?	
	TVS WSS CONCOVERS	NAMES OF THE OWNER.	AS UNDESSTORMEN	NEW CONTROL		
	Volght	22271	3510		is additional testing needed?	Comments:
				1497/01/07/20	For what	Oomments.
	Blood Pressure			NESAUNGARDANIANT	19	
1	end level-can be from	CANCEL MANAGEMENT OF THE PARTY			YesYes	
	2 or 24 months of age.	114-15	42		WIERI	750
	Al		TO THE WAY WAS AND A STATE OF THE PARTY OF T	Contract of the Contract of th	A STATE OF THE STA	A CONTRACTOR OF THE CONTRACTOR
*Please complete the following based ####################################						
on JFS form # 01305 (Rev. 3/2016)					lis Caparational estáblica de se La aboria do sel conjunta estáblica de se	Parent Declined
					and the first the history of the	Check any that
					programme and the state of the	have been
םן	iseases for immuniz	ation:		ins child cas	kijerijoji indriodkija kajo je	declined and sign
_				E TAID LULE		lamin. b∈low
Chicken pox Diphtheria						
Diphtheria						
Haemophilus influenzae type b						
Hepatitis A Hepatitis B						
	patitis B		We work to the	Property and		
Influenza						
Measles Mumps					( Si 18 2 )	
Measles					lassa asal <del>a </del> ara palawa Respectiv	
Mumps						
Pertussis Pneumococcal disease						_6.20.206
Poliomyalitia					Construction of the Constr	
Rotavirus						
Rubella						
Rotavirus Rubella Tetanus						
ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS						
I have declined to have my child immunized against one or more of the diseases listed above for reasons of conscience,						
including religious convictions. Signature of Parent:						
List any limitations or health conditions for this child (including allergies, daily medications, and dietary restrictions):						
his is to certify the following:						
This child is up-to-date according to the Ohio EPSDT schedule for preventative and primary health core.						
I have examined this child and found that s/he is in suitable condition for participation in group care.						
Ignature of Examining Physician/Physicians Assistant/Advanced Practical Nurse Date of Examination						
(X) Holy 1 m 17/20/17						
OX VIII VIII VIII VIII VIII VIII VIII VI						
ame address, phone of Physician/Physicians Assistant/Advanced Practical Nurse						
and the state of t						
We will the state of the state						
1805 Tamarack Rd, 220-564-4935.						
ilo Administrative Code Rules 5101.2-12-37 require that this examination be given no more than twelve months prior to the date						

of admission to the child care center or Type A home.