LEADS Head Start
P: 740-363-8810
F: 740-363-7627

HealthChek/Medical Examination

RECEIVED 8/17/17 KM

Return to: **LEADS Head Start/Early Head Start**

MANDATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing	8.14.17	passed	
Vision	8.14.17	passed	
Height	8.14.17	47 1/2"	
Weight	605.7# 8.14.17		
BMI			
Blood Pressure	105/72 8.14.17		

Required Blood Work	Date	Results	Follow-up?
Hct/Hgb			
Lead level- can be from 12 or 24 months of age.		pending	

Child's Name: Liliana Amparo **DOB:** 11.8.12

Center: _____

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

Is treatment/testing needed?	**Is treatment/testing complete?**
____Yes ✓ No ____N/A	____Yes ✓ No ____N/A
For what?	

Incomplete

Please complete the following based on JFS form # 01305 (Rev 12/2016)	**Physician/Physicians' Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes** *check all that apply*			**Parent Declined** *Parent initial any that have been declined and sign below*
Diseases for Immunization:	**Immunization in Process or Complete**	**Medically Contraindicated**	**Not Medically Appropriate for Age of Child**	
Chicken pox	☐	☐	☐	
Diphtheria	☐	☐	☐	
Haemophilus influenzae type b	☐	☐	☐	
Hepatitis A	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Influenza ☐ ***Seasonal Vaccine Not Available***	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal disease	☐	☐	☐	
Poliomyelitis	☐	☐	☐	
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: _____

This is to certify the following:

- This child is up-to-date according to the Ohio EPSDT 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.

Signature of Examining Physician/Physician's Assistant/Advanced Practical Nurse	Date of Examination:
APN	8.14.17

Name address, phone of Physician/Physician's Assistant/Advanced Practical Nurse:

DeAndrew MacDowell

OhioHealth Primary Care + Ped phys 801 OhioHealth Blvd Suite 200 Del Oh 43015

Ohio 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.

HSAC approval 07/17/2017