LEADS HealthChek/Medical Examination

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			
Vision			
Height	11-14-18	36 3/4	
Weight		29.8	
BMI		15.57	
Blood Pressure		90/54	

Required Blood Work	Date	Results	Follow-up?
Hct/Hgb	11-26-17	37.5/12.5	
Lead level- can be from 12 or 24 months of age.	10-4-17	< 2	

Child's Name: Katerina Brewer DOB: 9-7-14

Center: Buckeye Lake

Fax: (740) 928- 1603 Phone: (740) 928- 1123

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

Miralax daily

Is treatment/testing needed?	Is treatment/testing complete?
___Yes X No ___N/A	___Yes ___No X N/A
For what?	

Please complete the following based on JFS form # 01305 (Rev 12/2016) Diseases for Immunization: See Attached	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*
	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: [signature], APRN-CNP

Date of Examination: 11-14-18

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

Teresa Blanchard

LICKING MEMORIAL PEDIATRICS
1865 TAMARACK ROAD
NEWARK, OHIO 43055
(220)564-4940 FAX (220)564-4930

RECEIVED 11/15/18

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