

| Return to: LEADS Head S P: 740-928-11 MANDATORY | Child's Name: Bently Knox DOB: 1-17-14 | | | | | | | | |
|---|--|------------------------------|-----------------------------------|--|---------------------------|---------------------|--|---|--|
| EPSDT HealthChek | Date child received Results screen | | need | Center: Buckeye Lake Head Start Center | | | | | |
| Screenings: | | | follow-up? Y/N | *List any limitations or health conditions for this child (including | | | | | |
| Hearing | | 1 | 17.0 | allergies, daily medications, and dietary restrictions): | | | | | |
| /ision | 11/11 | | | | | | | | |
| leight | 628.18 3/1. Sinks 523-18 406 702 | | \$ | | | | | | |
| Veight | 572-18 | 4016 7cz | | | | | | | |
| BMI | 1 - 2 - 4 | 10111-00 | | Is treatment/testing needed? Is treatment/testing complete? | | | | | |
| Blood Pressure | 6.77-18 | 109/5 | F-11 | Yes | NoN/A | | | | |
| Required Blood Work | Date | Results | Follow- up? | For what? | | | | | |
| Hct/Hgb | 1-18-16 | 11,2 | | | | | | | |
| Lead level- can be from 12 or 24 months of age. | 1-18-16 | 420g/d | | | | | | | |
| *Please complete to on JFS form # 01305 | he following (5 (Rev 12/201 | | hysician/Physic | Nurse Practi | tioner Comp | Practice N letes | urse/Certified | Parent Declined Parent initial any that have been | |
| - | | | | | all that apply | 1 | + BAndies V. | declined and sign | |
| Diseases for Immunization: | | | Immunization in Process or Comple | | edically aindicated Ap | | ot Medically priate for Age of Child | below | |
| Chicken nov | | | | | | | | | |
| Chicken pox | | | | | | | | | |
| Diphtheria | | | | | | ; 🗆 | | | |
| Haemophilus influenzae type b | | | | | | | | | |
| Hepatitis A | | | | | | | | | |
| Hepatitis B | | | | | | | | | |
| Influenza | | | | 1 | | | | | |
| ☐ Seasonal Vaccine Not Available | | | | | | | | | |
| Measles | | | | | | | | | |
| Mumps | | | | | | | | 1 | |
| Pertussis | | | | | | | | | |
| Pneumococcal disease | | | | | | <u> </u> | | | |
| Poliomyelitis | | | | | | | | | |
| Rotavirus | | | | | | | | | |
| | | | | | | | | | |
| Rubella | | | П | | | | | | |
| Tetanus | IL A CORV OF | THE CHILD | S INANALINIZATI | ON RECORD W | ITH DATES C | F DOSES | OF ALL IMMUNIZ | ATIONS | |
| ☐ I have declined including religious | to have my of convictions. | child immur | nized against or | e or more of t | ne diseases I | isted abo | ve for reasons of | conscience, | |
| This is to certify the This child I have ex | l is up-to-date amined this c | e according the hild and fou | nd that s/he is | n suitable con | ition for par | истрации | Date (| of Examination: | |
| | | | | 100 | X NOTHEW |)W) | 4 | -, 22-18 | |
| Name address, p | | 100 | 1865 TAM | REMORPHISM ARACK ROAD OHIO 43055 -4935 FAX (220 | | urse. | | | |

Ohio Administrative Code Rules 5101.2-12-37 require that this examination be given no more than twelve months prior to the date HSAC approval 07/17/2017 of admission to the child care center or Type A home.

&Action LEADS

HealthChek/Medical Examination

| Return to: LEADS Head S P: 740-928-11 | tart/Early Head : 123 F: 740-928-1 | | | Child's Name: Bentley Knox DOB: 1/17/14 | | | | | |
|--|---------------------------------------|------------|---|--|---|--|--|--|--|
| MANDATORY EPSDT HealthChek Screenings: | Date child received screen | Results | Daes shild need fallow-up? Y/N | Center: *List any limitations or health conditions for this child (including allergies, daily medications, and dietary restrictions): | | | | | |
| Hearing | 77 | | | allergies, daily medical | tions, and dietary restrict | lous): | | | |
| Vision | NA | | T N | | | | | | |
| Height | 8110 | 37 | | | | | | | |
| Weight BMI | | 37.6 | + | *\ | | | | | |
| Blood Pressure | | 19/103/44 | | Is treatment/testing no | | testing complete? | | | |
| Required Blood Work Date Result | | | Follow- up? | YesNoN | .NoN/A | | | | |
| Hct/Hgb | 1/18/10 | 4.2 | | For what? | | | | | |
| Lead level- can be from 12 or 24 months of ego. | | 22 | N | | · | | | | |
| *Please complete th on JFS form # 01305 | - | | Physician/Physici | ans' Assistant/Advanced of Nurse Practitioner Comp check all that apply | Parent Declined Parent initial any that have been declined and sign below | | | | |
| Diseases for immunization: | | | Immunization in Process or Complet | Medically ce Contraindicated | | Not Medically Appropriate for Age of Child | | | |
| Chicken pox | | | Ü | | | | | | |
| Diphtheria | | | | | | | | | |
| Haemophilus influ | ienzae type | ь | | | | | | | |
| Hepatitis A | | | | | | · | | | |
| Hepatitis B | | | | | | | | | |
| Influenza | | | | V | | | | | |
| Influenza ☐ Seosonal Vaccine Not Available | | | | Phank | | | | | |
| Measles | | | | rd / | | | | | |
| | | | | ~ 0 0 D | | | | | |
| Mumps | | | | | | | | | |
| Pertussis | | | | | | | | | |
| Pneumococcal disease | | | | 4 8 | | | | | |
| Pollomyelitis | | | | | | 7 | | | |
| Rotavirus | | | | | | + | | | |
| Rubella | | | <u> </u> | | | | | | |
| Tetanus | | | | | | TATIONE | | | |
| ATTACH ☐ I have declined to Including religious of | to have my ch convictions. | iid immun | ilzed against one | N RECORD WITH DATES O or more of the diseases it | sted above for reasons o | conscience, | | | |
| This is to certify the This child i I have exam | s up-to-date a | ccording t | o the Ohio EPSDT | schedule for preventive a suitable condition for part | nd primary health care. Icipation in group care. | | | | |
| Signature of Exam | nining Physic | ian/Physi | cian's Assistant/ | Advanced Practical Nur N - CNP | Se Date | of Examination: | | | |
| Name address, ph | none of Physi | ician/Phy | SICIAN'S ASSISTANT LICKING MEMORIA 1865 TAMARACK R NEWARK, OHIO 43 (220)564-4934 PA | t/Advanced Practical No DAD 1055 x (220)564-4944 | ırse: | . | | | |
| Ohlo Administrative | e Code Rules 9 | 101.2-12- | 37 reguire that th | nis examination be given n | o more than twelve mont | hs prior to the date | | | |