HealthChek/Medical Examination

Return to: **LEADS Head Start/Early Head Start**
P: 740-928-1123 F: 740-928-1603

MANDATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing			
Vision	N/A		
Height	8.22.18	34.5inches	
Weight	8.22.18	40lb 7oz	
BMI			
Blood Pressure	8.22.18	104/50	

Required Blood Work	Date	Results	Follow-up?
Hct/Hgb	1-18-16	11.2	
Lead level- can be from 12 or 24 months of age.	1-18-16	<2ug/dl	

Child's Name: Bentley Knox **DOB:** 1-17-14
Center: Buckeye Lake Head Start 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?	

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: 8.22.18

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

LICKING MEMORIAL PEDIATRICS
1865 TAMARACK ROAD
NEWARK, OHIO 43055
(220)564-4935 FAX (220)564-4944

RECEIVED

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

Action LEADS HealthChek/Medical Examination

Return to: LEADS Head Start/~~Early Head Start~~
P: 740-928-1123 F: 740-928-1603

MANDATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing	NA		N
Vision			
Height	8/10/17	37	
Weight		37.6	
BMI		19	
Blood Pressure	✓	102/44	✓

Required Blood Work	Date	Results	Follow-up?
Hct/Hgb	1/18/16	41.2	
Lead level- can be from 12 or 24 months of age.	✓	<2	N

Child's Name: Bentley Knox DOB: 1/17/14
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?	

*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*	☐	☐ Parent	☐	
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:
Jean Frank APRN-CNP	8-10-17 BCT

Name address, phone of Physician/Physician's Assistant/Advanced Practical Nurse:
LICKING MEMORIAL PEDIATRICS
1865 TAMARACK ROAD
NEWARK, OHIO 43055
(220)564-4934 FAX (220)564-4944

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