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	N/A		
Vision			
Height	2/23/17	35½	
Weight		29	
BMI	↓	16	
Blood Pressure		78/30	

Required Blood Work	Date	Results	Follow-up?
Hct/Hgb	12/16/15	11.2	
Lead level- can be from 12 or 24 months of age.	↓	2	

Child's Name: Liara Fetter DOB: 9/30/13
Center: LC HS HB

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

Is treatment/testing needed?	Is treatment/testing complete?
X Yes ___No ___N/A	___Yes X No ___N/A
For what? Speech therapy	

*Please complete the following based on JFS form # 01305 (Rev 12/2016)	[illegible] Nurse Practitioner complete [illegible]			Parent Declined Parent initial any that have been declined and sign below
Diseases for Immunization:	[illegible]	[illegible]	[illegible]	
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	☐	☐	☐	

See attached

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:
[signature] CNP	2-23-17 BLT

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

Teressa Blanchard, CNP

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.

RECEIVED 9/19/17

HSAC approval 07/17/2017

LEADS LEADS HealthChek/Medical Examination

Return to: LEADS Head Start/Early Head Start 161 Wilson Street, Newark, Ohio 43055 Tara Maring: PH (740)349.7373 Fax (740)345.4303 Lindsay O'Dell: PH (740)258.6118 Fax (740)345.4303				Child's Name: Liara Getter DOB: 9/30/13	
MANADATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N	Is treatment needed? ____Yes ____No ____N/A For what?	Is treatment complete? ____Yes ____No ____N/A
Hearing	[illegible]		N		
Vision					
Height		[illegible]		Is additional testing needed? For what? ____Yes ____No ____N/A	Comments:
Weight		27.6			
BMI		[illegible]			
Blood Pressure					
[illegible]					
Lead level- can be from 12 or 24 months of age.	✓	<2			

*Please complete the following based on JFS form # 01305 (Rev 3/2015)	Physician/Physicians Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Complete (check all that apply)			Parent Declined Check 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:**

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

This is to certify the following:

- This child is up-to-date according to the Ohio EPSDT schedule for preventative 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/Physicians Assistant/Advanced Practical Nurse	Date of Examination
[signature]	12-16-2015

Name address, phone of Physician/Physicians Assistant/Advanced Practical Nurse

LICKING MEMORIAL PEDIATRICS
1865 TAMARACK ROAD
NEWARK, OH 43055
(740) 348-4934 FAX (740) 348-4944

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 05/13/2015

RECEIVED 10/12/16 NF

ENTERED ON: 10/12/16
BY: NF