RECEIVED 7/5/16 KM

LEADS LEADS HealthChek/Medical Examination

Return to:	Child's Name: Mohammed AlSaadon	DOB: 5/9/13
LEADS Head Start/Early Head Start Delaware Center 607 Sunbury Rd., Delaware, OH 43015 Phone: 740.363.8810 Fax: 740.363.7627		

MANADATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing	N/A		
Vision	N/A		
BMI	6/10/16	39.8	
Weight	6/10/16	39.8	
BMI	6/10/16	15.89 kg/m2	
Blood Pressure	6/10/16	108/65	
Hemoglobin	6/27/16	13.1	
Lead level- can be from 12 or 24 months of age.	6/27/16	<2	

Is treatment needed?	Is treatment complete?
____Yes ____No ____N/A For what?	____Yes ____No ____N/A
Is additional testing needed? **For what?** ____Yes ____No ____N/A	**Comments:**

Please complete the following based on JFS form # 01305 (Rev 3/2015)	Physician/Physicians' Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes *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, 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
	6/10/16

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

Community Pediatrics, Inc.
Enaas F. Kasheer, MD. FAAP
3966 Brown Park Drive, C & D
Hilliard Ohio, 43026
(614) 876-1304

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