LEADS HealthChek/Medical Examination

Return to: **LEADS Head Start/Early Head Start**

Child's Name: Hunter Brewer DOB: 7-24-14
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):

MANDATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing	NA		
Vision			
Height	7/24/14	30th	
Weight	7/24/14	39lb 2oz	
BMI	7/24/14	80/52	
Blood Pressure			

Required Blood Work	If Done	Results	Follow-up
Hct/Hgb	7/20/17	12.0	
Lead level- can be from 12 or 24 months of age.	7/20/17	<2	

Is treatment/testing needed? ____Yes ____No ____N/A
For what?

Is treatment/testing complete? ____Yes ____No ____N/A

Please complete the following based on JFS form # 01305 (Rev 12/2016)

Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes

Diseases for Immunization:	Immunization in Process or Complete	Medically Contraindicated	Not Medically Appropriate for Age or Child	Parent Declined Parent initial any that have been declined and sign below
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 OR 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]	8/17/18

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

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

RECEIVED 9/18/18