LEADS HealthChek/Medical Examination

Return to:
LEADS Head Start/Early Head Start Newark Center
986 East Main Street, Newark, OH 43055
Phone: 740.345.6415 Fax: 740.345-2305

Child's Name: Xilo Schlathman **DOB:** 8-30-13

MANADATORY EPSDT HealthChek Screenings:	Date child received screen	Results	Does child need follow-up? Y/N
Hearing			
Vision			
Height	9/13/16	36 1/2	
Weight	9-13-16	29.4	
BMI		15.57	
Blood Pressure	↓	92/54	
Hct/Hgb	9-1-15	11.1	
Lead level- can be from 12 or 24 months of age.	↓	<2	

Is treatment needed? ✓ enuresis
____Yes ____No ____N/A
For what?

Is treatment complete?
____Yes ____No ____N/A

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

Comments: recommend speech therapy

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):**
none

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]	9-13-16

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

RECEIVED 9/14/16

ENTERED ON FILE BK

LICKING MEMORIAL PEDIATRICS
1865 TAMARACK ROAD
NEWARK, OHIO 43055
(740)348-4940 FAX (740)348-4930

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