



## 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			
Vision			
Height	43 1/2		
Weight	41		
BMI	15.2		
Blood Pressure	96/50		
Required Blood Work	Date	Results	Follow- up?
Hct/Hgb			
Lead level- can be from 12 or 24 months of age.			

Child's Name: Aria McClain DOB: 11-26-2013  
 Center: Buckeye Lake

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

NONE

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/Physicians' Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes <i>check all that apply</i>			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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haemophilus influenzae type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza <input type="checkbox"/> Seasonal Vaccine Not Available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rotavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS				
<input type="checkbox"/> 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 <u>James W. Whetstone MD</u>	Date of Examination: <u>9/28/18</u>
Name address, phone of Physician/Physician's Assistant/Advanced Practical Nurse: Whetstone Medical Clinic P.O. Box 218 12135 Lancaster St. Millersport, OH 43046 760-667-2727	

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