LEADS

**Healthchek/Child’s Medical Statement**

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| Return to:  **LEADS Head Start – Marysville**  **111 Morey Drive** Marysville, Ohio 43040 **Phone: (937)642-1230 - FAX: (937)642-1996** | **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

**MANDATORY EPSDT Healthchek SCREENINGS Please Indicate:**

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|  | √ if child received screen | Results | Does child need follow-up? Y/N |
| **Hearing** |  |  |  |
| **Vision** |  |  |  |
| **Height** |  |  |  |
| **Weight** |  |  |  |
| **BMI** |  |  |  |
| **Blood Pressure** |  |  |  |
| **Hct/Hgb** |  |  |  |
| **Lead Level** – can be from 12 or 24 months of age |  |  |  |

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| Is treatment needed?  For what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Is treatment complete? |
| \_\_\_\_Yes \_\_\_\_ No \_\_\_\_N/A | \_\_\_\_Yes \_\_\_\_ No \_\_\_\_N/A |
| Is optional testing indicated?  For what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Comments: |
| \_\_\_\_Yes \_\_\_\_ No \_\_\_\_N/A |  |

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| **Immunizations (enter month, day and year or attach a printed record)** | | | | | |
| Vaccines | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
| Diphtheria, Tetanus, Pertussis (DTaP) |  |  |  |  |  |
| Hepatitis B (Hep B) |  |  |  |  |  |
| Haemophilus Influenza type b (HIB) |  |  |  |  |  |
| Measles, Mumps, Rubella (MMR) |  |  |  |  |  |
| Inactivated Polio |  |  |  |  |  |
| Varicella |  |  |  |  |  |
| Influenza |  |  |  |  |  |
| Pneumococcal Conjugate (PCV) |  |  |  |  |  |
| Rotavirus |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| **The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health** | | | | | |

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

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**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.**
* **This child has had the age appropriate immunizations recommended by the Ohio Department of Health.**
* **My office has entered the child’s immunizations record above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Signature of Examining Physician/Physician’s Assistant/Advanced Practice Nurse** | **Date of Examination** |

**Ohio Administrative Code rules 5101.2-12-37 and 5101-2-13-37 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.**

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| **Name of Physician/Physician’s Assistant/Advanced Practice Nurse** | **Telephone Number** |
| **Street Address** | |
| **City, State and Zip Code** | |

**Approved by HSSAC on 02/17/09 hchekmedstat**