Fax: 419-268-0017

MERCER COUNTY HEAD START
WELL CHILD/HEALTH CHECK/HEALTH ASSESSMENT/PHYSICAL

Child's Name _____ D.O.B. _____

Parent / Guardian Name _____ Phone _____

Address / City / State /Zip _____

BMI _____ Height _____ Weight _____ Head Circumference _____ Blood Pressure _____

Normal Weight ☐ Underweight ☐ Overweight ☐ Obese ☐ Under treatment due to weight issues ☐

Hematocrit / Hemoglobin Date / Result _____ Lead Screening Collection Date / Result _____

Check if normal (Please note any concerns below.)

Head ☐ Eyes ☐ Ears ☐ Nose ☐ Mouth ☐ Teeth/Gums ☐ Neck ☐ Heart ☐

Lungs ☐ Abdomen ☐ Anus ☐ Musculoskeletal ☐ Neuromuscular ☐ Skin ☐

Check if any apply

Anemia ☐ Asthma ☐ High Lead Level ☐ Diabetic ☐ Seizures ☐ Other _____

Urinalysis _____ TB _____ Sickle Cell Anemia _____

REQUIRED SCREENINGS

DEVELOPMENTAL	Pass ☐	Fail – Referred to: _____
VISION	Pass ☐	Fail – Referred to: _____
HEARING	Pass ☐	Fail – Referred to: _____
SPEECH	Pass ☐	Fail – Referred to: _____
SOCIAL/EMOTIONAL	Pass ☐	Fail – Referred to: _____

Concerns / Follow-Up (Please note any follow-up / special services or limitations.)

Diagnoses / Surgeries / Medications:

Allergies to Food / Medications:

By signing below, you the parent/guardian are giving permission for the above medical information to be release to Mercer County Head Start for your students' medical file. The above information is to be released for only up to one year of the signed date.

_____ _____ _____

Print Name of Parent/Guardian Signature of Parent/Guardian Date

******Please see reverse side for additional information.*******

Ohio Revised Code also allows parents/guardians to present written documentation that objects to the immunization of the student for good cause, including religious convictions and medical conditions.

I hereby object and request the school to waiver the immunization of my child against the following:

Please check all that apply:

Chicken Pox ☐	Hepatitis B ☐	Hepatitis A ☐
Diphtheria ☐	Tetanus ☐	Pertussis (Whooping Cough) ☐
Mumps ☐	Measles ☐	Rubella ☐
Rotavirus ☐	Influenzas (Seasonal) ☐	Polio ☐
Pneumococcal Disease ☐	Haemophilus Influenzae Type b (Hib) ☐	

If religious, good cause or medical reasons, please explain:

_____

_____

_____

I further understand that during the course of an outbreak of any kind, of the aforementioned vaccine-preventable diseases, which the child/student named here, is subject to exclusion from school for the duration of the outbreak. This action is necessary not only to protect the student, but the remainder of the students and staff.

_____ _____ _____

Print Name of Parent/Guardian | Signature of Parent/Guardian | Date

CHILD'S MEDICAL STATEMENT

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The 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:

_____

_____

_____ _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse **Date of Examination**

_____ _____

Name of Physician/Physician's Assistant/Advanced Practice Nurse | Telephone Number

_____

Name of Practice

_____

Street Address | City, State, Zip