Coshocton County Head Start Inc.
3201 CR 16
Coshocton, Ohio 43812
Hilltop – 740-622-9537 Fax 740-622-6351
This Physical is A EPSDT HEALTHCHEK Exam

The following services Must Be Completed and documented in full as required by the EPSDT rules and regulations and the Federal Head Start Regulations in order for the child to attend the Head Start Program.

Child's Name: _____D.O.B _____ Male: _____ Female_____

These Items **MUST BE COMPLETED** (IF LAB WORK CANNOT BE DONE IN YOUR OFFICE PLEASE SEND CHILD TO LAB)		
Date of Exam	**Height**	**Weight**
Blood Pressure	**Hct/Hgb**	**BMI**
Lead Level	**Hearing**	**Vision**

GENERAL ASSESSMENT

Health History
Medications
Does this child have any Allergies? **Yes** **No**
List Specific Allergies
Are there any ongoing health issues, Developmental/Social Emotional concerns or limitations that we should be aware of while this child is enrolled in our Head Start/Early Head Start program? Yes No Please Explain_____

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

	PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES Check all that apply for each disease		
Diseases for immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/Not Age Appropriate**
Chicken pox	○	○	○
Diphtheria	○	○	○
Hemophilus Influenza type b	○	○	○
Hepatitis A	○	○	○
Hepatitis B	○	○	○
Influenza ○ **Seasonal Vaccine Not Available**	○	○	○
Measles	○	○	○
Mumps	○	○	○
Pertussis	○	○	○
Pneumococcal disease	○	○	○
Poliomyelitis	○	○	○
Rotavirus	○	○	○
Rubella	○	○	○
Tetanus	○	○	○
○ **I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.**			
Signature of Parent **Date of Signature**			

IMMUNIZATIONS: This child has had the immunizations required by section 3313.671 of the ORC for admission to school or has had the immunizations required by the State Department of Health according to the child's age, or is to be exempted from these requirements for medical reasons.

○ **BASED ON THE CHILD'S MEDICAL HISTORY & PHYSICAL CONDITION AT THE TIME OF THIS EXAMINATION, THIS CHILD IS FREE OF APPARENT COMMUNICABLE DISEASE AND IS IN SUITABLE CONDITON FOR PARTICIPATION IN GROUP CARE.**

Physician's Signature_____Date of Exam_____

Address of Physician_____Phone Number_____

PLEASE SEND OR FAX THIS COMPLETED FORM TO THE ABOVE ADDRESS OR FAX TO ATTN TO: BRENDA BISSETT or CATY MARTIN