Northwestern Ohio Community Action Commission
HEAD START
Guiding Children and Families Toward Success

1933 E Second Street
Defiance, OH 43512
PH: 419-784-2150
Fax: 419-784-5048

Health Record Form

_____ ____/_____/_____ _____/_____/_____
Participant's Name Date of Birth Date of Examination

****Parent Signature** Authorization to Release Form to NOCAC** _____

☐ Prenatal ☐ Newborn ☐ 3-5 Day ☐ 1 mo. ☐ 2 mos. ☐ 4 mos. ☐ 6 mos. ☐ 9 mos.
☐ 12 mos. ☐ 15 mos. ☐ 18 mos. ☐ 24 mos. ☐ 30 mos. ☐ 3 yrs. ☐ 4 yrs. ☐ 5 yrs.

Section 1: Vital Signs

Height: _____ Weight: _____ Head Circumference (0-24 mos.) _____ Blood Pressure (ages 3 & up): _____

Section 2: Screenings

Well Child Exam/ Prenatal Visit	☐ **Normal** ☐ **Under Care** ☐ **Referred**
Oral Health Screening (Prenatal- 30 mos.)	☐ **Normal** ☐ **Under Care** ☐ **Referred**
Immunization Status **(PLEASE ATTACH CURRENT RECORD)**	☐ **Up to Date** ☐ **Under Care** ☐ **Waiver**
Hematocrit/Hemoglobin (required at 12 mo.) Last Date Tested: _____ Result: _____	☐ **Normal** ☐ **Under Care** ☐ **Referred**
Blood Lead Testing (required at 12 & 24 mo.) Date Tested: _____ Result: _____	☐ **Normal** ☐ **Under Care** ☐ **Referred**
Vision R: _____ L: _____	☐ **Pass** ☐ **Fail** ☐ **Referred** ☐ **Unable to Test**
Hearing R: _____ L: _____	☐ **Pass** ☐ **Fail** ☐ **Referred** ☐ **Unable to Test**

Section 3: Essential Finding/Special Conditions

List any allergies, chronic conditions, or special accommodations (including severe, life-threatening anaphylactic reactions, nutritional concerns, abnormal findings, and disabilities that must be supported by the program):

_____

_____

List medications required at center (include medication name and dosage):_____

_____

Under Treatment For: ☐ Seizures ☐ Heart Condition/Disease ☐ Asthma ☐ Emotional/Behavioral ☐ Diabetes ☐ Anemia ☐ Lead Poisoning ☐ Other: _____

The above-named participant has been examined, has had the immunizations required by Division 5104.014, Ohio Revised Code for Medical Statement of Immunization, the immunization status recorded, and the participant is in suitable condition for participation in group care.

_____ _____ _____
Provider Name ***(Print or Stamp)*** Phone Number Fax Number

_____ _____
Practice Name Address

_____ _____/_____/_____
Signature of Examining Physician, PA, APRN, CNP (Required) Date of Exam

White- CO Yellow- Participant's File Pink- Parent/Guardian