



# Health Record Form

1933 E Second Street  
Defiance, OH 43512  
PH: 419-784-2150  
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Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Examination \_\_\_\_\_

**\*\*Parent Signature\*\* Authorization to Release Form to NOCAC** \_\_\_\_\_

- Prenatal     1 month     2 months     4 months     6 months     9 months     12 months
- 15 months     18 months     24 months     30 months     3 years     4 years     5 years

## Section 1: Vital Signs

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

## Section 2: Screenings

Well Child Exam/ Prenatal Visit	<input type="checkbox"/> Normal	<input type="checkbox"/> Under Care	<input type="checkbox"/> Referred
Oral Health Screening (Prenatal- 30 mo)	<input type="checkbox"/> Normal	<input type="checkbox"/> Under Care	<input type="checkbox"/> Referred
Immunization Status (PLEASE ATTACH CURRENT RECORD)	<input type="checkbox"/> Up to Date	<input type="checkbox"/> Under Care	<input type="checkbox"/> Waiver
Hematocrit/Hemoglobin (required at 12 mo.) Last Date Tested: _____ Result: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Under Care	<input type="checkbox"/> Referred
Blood Lead Testing (required at 12 & 24 mo.) Date Tested: _____ Result: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Under Care	<input type="checkbox"/> Referred
Vision R: _____ L: _____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Referred <input type="checkbox"/> Unable to Test
Hearing R: _____ L: _____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Referred <input type="checkbox"/> 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 cannot 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 104.014, 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 \_\_\_\_\_