Community Action Commission of Erie, Huron & Richland Counties, Inc.
Head Start and Early Head Start Program

Date _____ Phone Number _____

Child's Name_____ Date of Birth _____

Parent/Guardian's Name _____

Address _____

Email _____

How did you first hear about the Head Start/Early Head Start Program?

Please circle all that apply.

Community Partner Friend Past/Present HS/EHS Parent Social Media

Other _____

Follow up Information_____

Referred By _____ Location _____

ERSEA: Rev. 07/2020

Community Action Commission
of Erie, Huron & Richland Counties, Inc.

Head Start and Early Head Start Program
Eligibility, Recruitment, Selection, Enrollment, and Attendance - 1302

Welcome to CACEHR Head Start and Early Head Start

Head Start and Early Head Start Programs provide high-quality education and child development services that promote children's cognitive, social, and emotional growth for later success in school, including for children with disabilities. Families who have children with diagnosed or suspected disabilities are encouraged to apply. Head Start and Early Head Start services are provided free of charge to those families that meet the requirements of the child's age and the family's income. Head Start and Early Head Start Programs recognize parent/guardian's roles as children's lifelong educators and encourage all parents/guardians to engage in their child's education.

Head Start/Early Head Start Enrollment Application (Please complete in blue or black ink).

Upon receipt of the documents listed below, your eligibility will be determined.

☐ - Child's birth certificate

☐ - Child's Social Security Card

☐ - Income Verification (W2, 30 days of pay stubs, etc.)

☐ - Medicaid or private insurance card

☐ - Immunization (shot) record

☐ - Custody papers (if applicable)

☐ - Individualized Education Plan (IEP/IFSP)

Three Locations to Serve You

Sandusky Office
908 Seavers Way
Sandusky, Oh 44870
419-625-2214

Norwalk Office
92 Prospect Street
Norwalk, OH 44857
419-668-9823

Willard Office
1530 South Conwell
Willard, OH 44890
419-935-6481

Applicant & Family Member Information

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Primary Health Coverage | Other Coverage | Insurance #

Medicaid Eligibility
☐ Not Eligible ☐ On Medicaid ☐ Potentially

Medicaid # | Doctor/Medical Home

Dental Coverage | Dental Coverage # | Dentist/Dental Home

Primary Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ < Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ < Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living at Date | Living Address | Address Line 2 | ZIP | City | State | County

Family Mailing Address

Same as living? ☐ Yes ☐ No | Started Using Date | Mailing Address | Address Line 2 | ZIP | City | State

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt in for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Acquired/learning another language in addition to English	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP	WIC
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Family Income

Income Verified by | Verification Date | TANF Status ☐ Yes ☐ No ☐ Formerly on TANF/Not now | SSI ☐ Yes ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts

Contact 1

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 2

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 3

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature _____ Date _____

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number
Parent/Guardian Name		Relationship to Child
Home Address		Home Telephone Number
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name		Relationship to Child
Home Address		Home Telephone Number
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give ***Permission*** **to Transport**			***Do Not Give Permission*** **to Transport**	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**OR** Do not sign both	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Community Action Commission of Erie, Huron & Richland Counties, Inc.
Head Start and Early Head Start Program
Eligibility Recruitment Selection Enrollment & Attendance - 1302
Confidentiality and Release of Information Policy

In the Head Start Program, all Head Start staff, volunteers, and agency consultants may know the information about other people involved in the program; therefore, we are in a "confidential relationship." Confidential information includes information including but not limited to enrollment information, written Parent/Teacher Conferences, and Home Visits Reports.

It is the responsibility of all Head Start staff, volunteers, and agency consultants to honor this "confidential relationship" and protect the privacy of others by not discussing Head Start information outside the work place.

All Head Start files are confidential and access is limited to a "Need to Know" basis to all Head Start staff and agency consultants. Parent volunteers do not have access to Head Start files.

Head Start parents (defined as those people who are legally responsible for the child), may have timely access to their child's Head Start file after they have scheduled an appointment with the appropriate supervisor to review the file. The Head Start supervisor or designated paid staff person will be present the entire time the parent is reviewing the child's file. Information is the child's file may be copied for the parent.

Note: All written entries in the child's file will contain statements of fact, without judgment and/or opinions. This applies to all entries in all files. Lawyers coming in person with current signed and dated release of information forms (less than three months old), from the Head Start parent may have access to the child's file under the same policy as noted above for the parent. Request for information must be in writing, signed, and dated by the parent or legal guardian of the child. Information can be mailed under a cover memo, signed and dated by the appropriate staff person.

The Head Start Director or his/her designee handles all telephone requests for confidential information. All subpoenas are reported to the appropriate supervisor. Head Start staff will refer anyone requesting confidential information to his/her immediate supervisor.

The President/CEO of Community Action Commission of Erie, Huron & Richland Counties, Inc. may make exceptions to this policy.

I read, understand, and agree to comply with this policy. I understand that this policy remains in effect until revised or canceled in writing.

Parent/Guardian's Signature_____ Date:_____

Staff's Signature_____ Date:_____

Community Action Commission of Erie, Huron & Richland Counties, Inc.
Head Start and Early Head Start Program
Eligibility Recruitment Selection Enrollment and Attendance – 1302.16

Attendance Promise

All families are encouraged to ensure that their child maintain regular and consistent attendance in the Head Start and Early Head Start Program. Staff will support families in identifying barriers for regular attendance and initiate support when requested or deemed necessary. Families will be contacted daily when absences occur. After the second consecutive day of absences without contact; staff will conduct a home visit. If the family cannot or will not provide reasonable explanation for the child's absence; the child will be placed on the waiting list. The vacant slot will be offered to the next eligible family on the waiting list. When the family is ready and the child is able to return, the child will be re-enrolled into the program providing there is an opening available.

I, _____parent/guardian of_____
(please print) (name of child)
Promise to ensure that my child will attend Community Action Commission of Erie, Huron & Richland Counties, Inc. Head Start and Early Head Start Program on a regular and consistent basis. I also agree to contact the center when my child will be absent and I understand that I will be contacted by staff in the event I am unable to contact the center.

By signing this promise we are working together to guarantee that your child has many educational opportunities. On behalf of the Community Action Commission of Erie, Huron & Richland Counties, Inc. Head Start and Early Head Start Program, I will sign in good faith to offer support and assistance however and whenever necessary to guarantee each day is a positive and productive experience for you, your child, and your family.

Parent/Guardian's Signature_____ Date_____

Staff's Signature _____ Date_____

Reviewed By _____ Date _____

Reviewed By _____ Date _____

Reviewed By _____ Date _____

Reviewed By _____ Date _____

Reviewed By _____ Date _____

Community Action Commission of Erie, Huron, & Richland Counties,
Head Start and Early Head Start Program

Transportation Information/Special Release Form

This form is to be completed by the parent or the legal guardian.

Child's Name (print)_____

____ I give CACEHR Head Start permission to transport my child.

____ I do not give CACEHR Head Start permission to transport my child.

(Pick up location) _____ Bus # ____
(Drop-off location)_____ Bus # ____

I, (please print) _____give CACEHR Head Start/Early Head Start permission to release my children to their brother, sister, or other individual named below. I accept full responsibility for my child escorting their brother(s) or sister(s) to and from the Head Start Center or bus stop. (Note: A child shall only be released to persons sixteen years of age or older, except when the parent or the guardian's written permission is on file.)

(Please print)

1. Name_____ Relationship_____
2. Name_____ Relationship_____
3. Name _____ Relationship_____

Field Trip Authorization

My child has permission to participate in walking fieldtrips. _____ Yes _____ No

Photograph, Video, & Social Media Authorization

Permission is granted for photographs/videos to be taken of my child for program activities and participation (ie: fieldtrips, classroom, center, etc.) ____ Yes _____ No

Permission is granted for my child to be photographed or videoed for publication (ie: agency & center's newsletter, newspaper, television, Facebook, Instagram, Twitter, Social Media Outlooks.) _____ Yes _____ No

****CACEHR is not responsible for photos taken without permission/authorization. Our social media is linked; if posted on a publication it will automatically go to all sites.***

I have read and understand.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Site Administrator/Teacher Supervisor's Signature Date

_____
Family Service Advocate's Signature Date

Community Action Commission
of Erie, Huron & Richland Counties, Inc.

Head Start and Early Head Start
Subpart D - Health Program Services 1302.42 1302.43

Child Medical Statement and Oral Health Letter

Parents/Guardian,

Included with this application packet is the **Child Medical Statement for Child Care** and the **Head Start Oral Health Care Form. Please take these forms with you to your child's appointment.**

Please be advised that a complete medical exam and an oral exam is required. These services must be completed in full, and signed by the Medical Health Care Provider within thirty (30) days) and Oral Health Care Provider, within ninety (90) days of enrollment. Upon the completion of the physical exam and dental exam, return the form to your Site Administrator, or Family Service Advocate where your child attends.

If your child is without an ongoing source of continuous, accessible health care, a medical home provider, and you would like some assistance in accessing one, please contact the Site Administrator (SA) or Family Service Advocate (FSA) at the center.

Thank you for attending to your child's preventative health care and supporting our Head Start/Early Head Start Program. If you have any questions or concerns please contact the SA, FSA, or me at 419-625-3015 x 210.

Sincerely

Catherine Miller
Health Services Manager

Early Childhood National Centers
NATIONAL CENTER ON
Early Childhood Health and Wellness

CAC of Erie Huron & Richland Counties, Inc.
Head Start/Early Head Start
908 Seavers Way
Sandusky, Ohio 44870
(P) 419-625-2218 (F) 419-625-1868

Head Start Oral Health Form

Patient Information

Pregnant woman's/child's name _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the pregnant woman's/child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the pregnant woman or child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the pregnant woman or child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Does the pregnant woman have gum disease? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No
Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #9OHC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

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

Street Address

City, State and Zip Code

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

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		