The Learning Coalition

Child's Name____DOB________________Sex________Race______

These screenings are required for the Ohio EPSDT Program

Vision Test	Hearing Test	Blood Pressure	Length/Height	Weight	Sickle Cell Disease?
Date:	Date:	Date:	Date:	Date:	◯ Yes ◯ No
Acuity:	dB:	Result:	Result:	Result:	Sickle Cell Trait?
Strabismus:	Hz:	TB Risk ◯ Yes ◯ No	Sickle Cell Test Date: Result:		◯ Yes ◯ No

Hemoglobin		Hematocrit		Lead	
Date:	Result:	Date:	Result:	Date:	Result:
NEWBORN HEARING SCREENING RESULTS		NEONATAL VISION Looks at faces/Fixes and follows		NEONATAL HEARING Responds to voice/noise/noisemaker	
PASS	REFER	◯ Yes	◯ No	◯ Yes	◯ No

EXAMINATIONS and/or INSPECTIONS

	Normal	Abnormal	Referred
Eyes			
Ears, Nose, Throat			
Teeth			
Thyroid			
Lymphatic System			
Heart-Vascular			
Lungs			
Breasts			
Abdomen			
Genitalia			
Neurological Syst.			
Skin			
Extremities			
Spine			
Speech/ Language			

Essential findings deviating from normal and/or recommendations

Current Medications:

Allergies (food and/or environmental):

Please attach IMMUNIZATIONS (note any exceptions below)

By signing below, I certify that this child:

- Has been examined, immunization status recorded, and the child is in suitable condition for participation in group care.
- Has been immunized and shots are up to date in accordance with the requirement of ORC section 5104.014.
- Is up-to-date per the requirement of EPSDT

____________________ **Physician/Examiner's Name**

____________________ **Physician/Examiner's Signature**

____________________ **Clinic Phone number**

____________________ **Date of Exam**

____________________ **Clinic Name and Address or stamp**