Verification of Child's Health
Head Start

This is to certify that ______________________________, has been seen and the following results were completed.

Hemocrit / hemoglobin results were ________________________.

Date__________. Provider:_______________________________.

Lead blood screening results were___________________________.

Date____________. Provider:_______________________________.

Blood Pressure results were ____________________ Date_______.

Provider__________________________.

Comments:____

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Staff Initials: ____________________ Date: _____________