Verification of Child's Health
Head Start

This is to certify that _____, has been seen and the following results were completed or on file at provider office.

Hematocrit / Hemoglobin results were _____.

Date_____. Provider: _____.

Lead blood screening results were_____.

Date_____. Provider: _____.

Blood Pressure results were _____ Date_____.

Provider_____.

Comments: _____

_____

_____

Staff Initials: _____ Date: _____