Screen Date _____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

7 and 8 Year Form

Name_____ DOB_____ Age_____ Sex: M F Wt_____ Ht_____ BMI_____ BP_____ Pulse_____ Temp_____

Allergies: □ NKDA _____ Current Meds: □ None_____

Accompanied by: □ Parent □ Grandparent □ Foster parent □ Foster organization □ Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
□ **UTD** □ Given, see vaccine record

□ **Vision Acuity Screen** *(Obj @ 8 yrs)* R _____ L _____
Wears glasses □ Yes □ No

□ **Hearing Screen** *(Obj @ 8 yrs)*
as indicated by risk screen: 20 db@
R ear:____ 500HZ R ear:____ 1000HZ ____ 2000HZ _____ 4000HZ
L ear:____ 500HZ L ear:____ 1000HZ ____ 2000HZ _____ 4000HZ
Wears hearing aids □ Yes □ No

Oral Health Screen
Date of last dental visit_____
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current oral health problems:

□ **Developmental Surveillance**

Referrals: □ Behavioral/Mental Health □ Dentist □ Vision
□ Hearing □ CSHCN **1-800-642-9704**

Provider signature required for validation
□ **Risk indicators reviewed/screen complete**

_____
Please Print Name of Facility or Clinic

_____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Social Emotional Health/Interpersonal Trauma[1]

Social/Family: ***✓ Check those that apply***
□ Family situation change □ No change

_____
Have you lived anywhere but with parent(s)/caretaker(s)?
□ Yes □ No _____
Parent(s)/Caretaker(s) working outside home? □ Yes □ No
Child care? □ Yes □ No _____
Sibling(s) in the home? □ Yes □ No _____
Do you get along with other family members? □ Yes □ No
If you could, how would you change your life?
home? _____
family?_____

Social Emotional/Stress Indicators: ***✓ Check those that apply***
Friend(s): □ Yes □ No
Fun activities: _____
Feelings: □ Okay/content
□ Angry □ Less than a week □ More than a week
□ Down/depressed □ Less than a week □ More than a week
□ Poor self image □ Experienced an emotional loss
Thoughts/plans to harm □ Self □ Others □ Animals □ NA
Have you ever had a really scary or bad experience that you cannot forget? □ Yes □ No _____
Do you have bad dreams or nightmares? □ Yes □ No

_____

Has anyone ever hit, choked, kicked or hurt you? □ Yes □ No

_____
Do your friends ever ask you to do things you don't want to do?
□ Yes □ No _____
Has anyone ever touched you where your bathing suit goes or made you touch them when you did not want to? □ Yes □ No

_____

Risk Indicators: ***✓ Check those that apply***
□ Lack of physical activity □ Weight or height concerns
Exposure to: □ Passive Smoke □ Cigarettes □ E-Cigs □ Chew
□ Alcohol □ Other drugs_____
□ Access to weapon(s) □ Has a weapon(s) □ Trouble with the law
Do you wear protective gear, including seat belts? □ Yes □ No
□ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
School/Grade_____
□ Attends school regularly
How are you doing in school?_____
□ Math at grade level □ Reads at grade level
□ Special classes_____
□ Trouble at school _____
□ Participates in extracurricular activities_____

Sex education
□ Sex education/questions

Physical Health

Current Health Indicators: ***✓ Check those that apply***
□ No change
Changes since last visit:

Nutrition: ***✓ Check those that apply***
□ Normal eating habits_____
□ Vitamins:_____
□ Normal elimination □ Normal sleep patterns

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
Dyslipidemia Risk: □ Low risk □ High risk
Tuberculosis Risk: □ Low risk □ High risk

Physical Examination: ***✓= Normal limits***

□ General Appearance	□ Skin	□ Neurological
□ Reflexes	□ Head	□ Neck
□ Eyes	□ Ears	□ Nose
□ Oral Cavity/Throat	□ Lungs	□ Heart
□ Pulses	□ Abdomen	□ Genitalia
□ Back	□ Extremities	
Possible Signs of Abuse	□ Yes □ No	

Health Education/Anticipatory Guidance:

□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Assessment: □ **Well Child** □ **Other Diagnosis**

Labs:

Referrals*: (*see above)* □ Other
**** See Provider Manual for automatic referrals***

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: □ 8 years of age
□ 9 years of age □ Other

[1] Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. **For assistance phone 844-HELP4WV (844-435-7498).**