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).**

WVDHHR/BPH/OMCFH/HC 10-2015

West Virginia Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH