

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

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 _____

Vision Acuity Screen (obj) R _____ L _____
 Unable to obtain, re-screen in 4-6 month
 Wears glasses Yes No

Hearing Screen (Subjective screen required at 3)
 Do you think your child hears okay? Yes No
 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

Developmental Surveillance: Check those that apply
Gross Motor: Jumps in place Kicks ball Rides tricycle
 Up/down stairs alternating feet
Fine Motor: Uses cup, spoon and fork Has manual dexterity
 Builds a tower with 6 or 8 cubes Copies a circle
Communication: Speaks intelligibly
 Uses 3-4 word sentences Short paragraphs
 Uses plurals and pronouns
Cognitive: Follows 2 step instructions
 Aware of gender (of self and others)
 Knows name, age and sex Names most common objects
Social: Listens to stories Shows early imaginative behavior
 Plays interactive games with peers (able to take turns)

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

Referrals: Developmental Emotional Dentist Vision
 Hearing Blood lead 10 \geq ug/dl 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: _____

Risk Indicators: Check those that apply
 Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs _____
 Are there weapon(s) in the home? Yes No
 Are the weapon(s) secured? Yes No NA
 Do you utilize a car/booster seat for your child? Yes No
 Excessive television/video game/internet/cell phone use
 Hours per day: _____ Who supervises usage? _____
 Pre-school Yes No
 Attends school regularly _____ NA
 Special classes _____ NA
 Participates in extracurricular activities _____

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

Physical Examination: = Normal limits
 General Appearance Skin
 Neurological Reflexes
 Head Neck
 Eyes Red Reflex Ocular Alignment
 Nose Ears Oral Cavity/Throat
 Lungs Heart Pulses
 Abdomen Genitalia
 Back Extremities

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____
 Parent(s)/Caretaker(s) working outside home? Yes No
 Child care? Yes No _____
 Ability to separate from parent(s)/caretaker(s)? Yes No
 Sibling(s) in the home? Yes No _____
 Gets along with other family members? Yes No

Physical Health

Current Health Indicators: Check those that apply
 No change
 Changes since last visit: _____

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

Assessment: Well Child Other Diagnosis

Labs: Blood lead, if needed or high risk

Referrals: (see above) Other

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: 4 years of age Other

Social Emotional/Stress Indicators: Check those that apply
 Is there stress in the home? Yes No

Has your child ever had a really scary or bad experience that they cannot forget? Yes No _____
 Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

¹ Some responses may indicate adverse childhood experiences. 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).