Screen Date_____

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

5 and 6 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(5 years, apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can balances on one foot, hops and skips
☐ Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles
☐ Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors
☐ Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance

☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma- **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

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

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____
_____
How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Child's grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/Vegetables/Lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk** *(year 6)*
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Neighborhood and family violence
- ☐ Food security
- ☐ Family substance use (tobacco, alcohol, drugs)
- ☐ Emotional security and self-esteem
- ☐ Connectedness with family

Developmental and Mental Health
- ☐ Family rules and routines
- ☐ Concern and respect for others
- ☐ Patience and control over anger

School
- ☐ Readiness
- ☐ Established routines and school attendance
- ☐ Friends
- ☐ After school care
- ☐ Parent -teacher communication

Physical Growth and Development
- ☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
- ☐ Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, healthy foods in school)
- ☐ Physical activity (60 minutes per day)

Safety
- ☐ Car safety
- ☐ Outdoor safety
- ☐ Water safety
- ☐ Sun protection
- ☐ Harm from adults (sexual abuse)
- ☐ Home fire safety
- ☐ Firearm safety

☐ Other
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk)* *(enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(year 6, if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 6 years of age ☐ 7 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature