**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

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 _____

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

**Oral Health**
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ 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 Surveillance**
Concerns about behavior, speech, learning, social or motor skills_____
_____
_____

**Referrals**:
☐ 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 parents/caregivers 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_____
_____

Grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

## Risk Indicators (✓ *Check those that apply)*

**Exposure 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_____
_____
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

**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?_____

**Continue on page 2**

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

***See Periodicity Schedule for Risk Factors***

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

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

***Dyslipidemia Risk**
☐ 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 | _____ |
| 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 (bullying, fighting)
- ☐ Food security
- ☐ Family substance use (tobacco, alcohol, drugs)
- ☐ Harm from the internet
- ☐ Emotional security and self-esteem
- ☐ Connectedness with family and peers

**Developmental and Mental Health**
- ☐ Independence, rules and consequences, temper problems and conflict resolution
- ☐ Puberty and pubertal development

**School**
- ☐ Adaption to school, school problems (behavior or learning issues), school performance and progress, school attendance, individual education program or special education services, involvement in school activities and after-school programs

**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, limiting added sugars intake)
- ☐ Physical activity (60 minutes per day, screen time)

**Safety**
- ☐ Car safety
- ☐ Safety during physical activity
- ☐ Water safety
- ☐ Sun protection
- ☐ Harm from adults (physical/sexual abuse)
- ☐ Firearm safety

**☐ Other**

## Plan of Care

**Assessment ☐ Well Child ☐ Other Diagnosis**

**Labs**
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ TB skin test *(if high risk)*
- ☐ Lipid profile *(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** ☐ 8 years of age ☐ 9 years of age
☐ Other_____

**☐ Screen has been reviewed and is complete**

**See page 1, school requirements for required signature**