



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

4 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Newborn metabolic screen  NL  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

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

Caretaker(s) working outside home?  Yes  No  
 Child care?  No  Yes \_\_\_\_\_  
 Other changes since last visit:

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

GROWTH PLOTTED ON GROWTH CHART  
 Normal elimination  Normal sleep patterns  
 Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_  
 Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Formula \_\_\_\_\_  
 Juice  Water  
 Has started solid foods  Start solid foods  
 Vitamins \_\_\_\_\_  
 Comments:

Passive Smoking Risk:  Yes  No

Check those that apply  
 Hemoglobin/Hematocrit Risk:  Low risk  High risk  
 See Periodicity Schedule for risk indicators

Developmental Surveillance:  Check those that apply  
 Gross Motor:  
 Holds head erect  
 Raises body on hands with head up  
 Rolls front to back

Fine Motor:  
 Reaches for and grabs objects  
 Brings hands together  
 Begins to bat at objects  
 Sensory:  
 Responds to sounds  
 Follows objects with eyes  
 Looks at and may become excited by mobile  
 Recognizes parent's voice and touch

Communication:  
 Coos  
 Blows bubbles, makes "raspberry sounds"  
 Social:  
 Social smile  
 Laughs or squeals  
 Able to comfort self (e.g., falls asleep without breast or bottle)  
 Comments:

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Water source:  
 Public  
 Well  Tested

Current oral health problems:

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

Abnormal Findings and Comments:  
 Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:  
 Discussed  Handout(s) given  
 Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, promotion of parent-infant interaction, family relationships, and community interaction  
 Other:

Assessment:  Well Child  Other diagnosis  
 Risk indicators reviewed/screen complete

Plan/Referrals:  
 For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record  
 Labs:

Referrals:  Developmental  
 RFTS  BTT  CSHCN 1-800-642-9704  
 Other referral(s)

Follow Up/Next Visit:  6 months of age  Other

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title





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

6 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Newborn metabolic screen  NL  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History:  Check those that apply

- No change
- Family situation change

Caretaker(s) working outside home?  Yes  No

Child care?  No  Yes \_\_\_\_\_

Other changes since last visit:

Current Health Indicators:  Check those that apply

- No change
- Changes since last visit:

GROWTH PLOTTED ON GROWTH CHART

- Normal elimination
- Normal sleep patterns

Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_

- Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_
- Formula \_\_\_\_\_
- Juice  Water
- Has started solid foods  Normal eating habits
- Vitamins \_\_\_\_\_

Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

Tuberculosis Risk:  Low risk  High risk

- Increased risk of exposure d/t Contacts/Travel/Immigration
- Radiographic or clinical findings suggestive of TB

Lead Risk:  Low risk  High risk

- Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
- Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
- Has a sibling or playmate who has or did have lead poisoning?

Developmental Surveillance:  Check those that apply

- Gross Motor:
  - Sits with support
  - Rolls over
  - Stands when placed and bears weight
- Fine Motor:
  - Transfers objects from hand to hand
  - Starts to self-feed; grasps and mouths objects
  - Rakes in small objects
- Communication:
  - Vocalizes single consonants ("dada", "baba")
  - Babbles, laughs and squeals
  - Plays by making sounds
  - Shows interest in toys

Social:

- Social smile
- Shows pleasure
- Shows differential recognition of parents
- May begin to show signs of stranger anxiety
- Self comforts

Comments:

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Water source:

- Public
- Well  Tested

Current oral health problems:

Physical Examination:  = Normal limits

- General Appearance
- Neurological
- Head
- Eyes
- Ears
- Oral Cavity/Throat
- Lungs
- Abdomen
- Back
- Skin
- Reflexes
- Neck
- Ocular Alignment
- Fontanelles
- Red Reflex
- Nose
- Heart
- Hips
- Pulses
- Genitalia
- Extremities

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

- Discussed
  - Handout(s) given
- Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction

Other:

Assessment:  Well Child  Other diagnosis

Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record

Labs:  Blood lead, if high risk

Referrals:  Developmental

- RFTS  BTT  CSHCN 1-800-642-9704
- Other referral(s)

Follow Up/Next Visit:  9 months of age  Other

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title



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

9 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

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

Caretaker(s) working outside home?  Yes  No  
 Child care?  No  Yes \_\_\_\_\_  
 Other changes since last visit:

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

GROWTH PLOTTED ON GROWTH CHART  
 Normal elimination  Normal sleep patterns  
 Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_  
 Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Formula \_\_\_\_\_  
 Milk  Juice  Water  
 Has started solid foods  Normal eating habits  
 Vitamins \_\_\_\_\_  
 Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

Lead Risk:  Low risk  High risk  
 Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

Developmental Surveillance & Screening:  
 Standardized Screening Tool:  
 ASQ3 Other: \_\_\_\_\_  
 Results in chart/record  Yes  No  
 Comments:

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Water source:  
 Public  
 Well  Tested  
 Current oral health problems:

Physical Examination:  = Normal limits

<input type="checkbox"/> General Appearance	<input type="checkbox"/> Skin
<input type="checkbox"/> Neurological	<input type="checkbox"/> Reflexes
<input type="checkbox"/> Head	<input type="checkbox"/> Neck
<input type="checkbox"/> Eyes	<input type="checkbox"/> Ocular Alignment
<input type="checkbox"/> Ears	<input type="checkbox"/> Nose
<input type="checkbox"/> Oral Cavity/Throat	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Heart
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pulses
<input type="checkbox"/> Back	<input type="checkbox"/> Genitalia
	<input type="checkbox"/> Extremities

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

Discussed  Handout(s) given  
 Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction  
 Other:

Assessment:  Well Child  Other diagnosis  
 Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record  
 Labs:  Blood lead, if high risk

Referrals:  Developmental  Blood lead  $\geq$  10 ug/dl  
 RFTS  BTT  CSHCN 1-800-642-9704  
 Other referral(s)

Follow Up/Next Visit:  12 months of age  Other

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title



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

12 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History:  Check those that apply

- No change
- Family situation change

Caretaker(s) working outside home?  Yes  No

Child care?  No  Yes \_\_\_\_\_

Other changes since last visit:

Current Health Indicators:  Check those that apply

- No change
- Changes since last visit:

GROWTH PLOTTED ON GROWTH CHART

- Normal elimination  Normal sleep patterns

Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_

Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Formula \_\_\_\_\_

Milk  Juice  Water

Has started solid foods  Normal eating habits

Vitamins \_\_\_\_\_

Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

Tuberculosis Risk:  Low risk  High risk

Increased risk of exposure d/t Contacts/Travel/Immigration

Radiographic or clinical findings suggestive of TB

Lead Risk: Blood lead required at 12 months

Developmental Surveillance:  Check those that apply

Gross Motor:

- Pulls self to standing  Crawls
- Walks with support

Fine Motor:

- Feeds self with fingers, drinks from cup
- Pincer grasp
- Bangs two blocks together

Communication:

- Uses 1- 2 words
- Imitates vocalizations and sounds\*
- Babbling\*

Social:

- Protodeclarative pointing\*
- Social smile  Waves bye-bye
- Peekaboo  Looks at pictures
- Patty-cake  Looks for dropped or hidden objects

Comments:

\*Absence of these milestones= Autism Screen

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Water source:

- Public
- Well  Tested
- Fluoride  Yes  No

Tooth eruption

Current oral health problems:

Physical Examination:  = Normal limits

- |   |   |
|---|---|
| <input type="checkbox"/> General Appearance | <input type="checkbox"/> Skin             |
| <input type="checkbox"/> Neurological       | <input type="checkbox"/> Reflexes         |
| <input type="checkbox"/> Head               | <input type="checkbox"/> Neck             |
| <input type="checkbox"/> Fontanelles        | <input type="checkbox"/> Ocular Alignment |
| <input type="checkbox"/> Eyes               | <input type="checkbox"/> Red Reflex       |
| <input type="checkbox"/> Ears               | <input type="checkbox"/> Nose             |
| <input type="checkbox"/> Oral Cavity/Throat |   |
| <input type="checkbox"/> Lungs              | <input type="checkbox"/> Heart            |
| <input type="checkbox"/> Abdomen            | <input type="checkbox"/> Pulses           |
| <input type="checkbox"/> Back               | <input type="checkbox"/> Genitalia        |
| <input type="checkbox"/> Hips               | <input type="checkbox"/> Extremities      |
| <input type="checkbox"/> Gait               |   |

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

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

Assessment:  Well Child  Other diagnosis

Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record

Labs:  HGB/HCT required at 12 months

Blood lead required at 12 months

Referrals:  Dentist  Developmental

Blood lead  $\geq$  10 ug/dl

BTT  CSHCN 1-800-642-9704

Other referral(s)

Follow Up/Next Visit:  15 months of age  Other

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title



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

15 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History:  Check those that apply

- No change
- Family situation change

Caretaker(s) working outside home?  Yes  No

Child care?  No  Yes \_\_\_\_\_

Other changes since last visit:

Current Health Indicators:  Check those that apply

- No change
- Changes since last visit:

GROWTH PLOTTED ON GROWTH CHART

- Normal elimination  Normal sleep patterns

Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_

Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Formula \_\_\_\_\_

Milk  Juice  Water  Normal eating habits

Vitamins \_\_\_\_\_

Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

Hemoglobin/Hematocrit Risk:  Low risk  High risk

See Periodicity Schedule for risk indicators

Tuberculosis Risk:  Low risk  High risk

Increased risk of exposure d/t Contacts/Travel/Immigration

Radiographic or clinical findings suggestive of TB

Lead Risk:  Low risk  High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead poisoning?

Developmental Surveillance:  Check those that apply

Gross Motor:

Walks well, stoops, climbs stairs

Fine Motor:

Feeds self with fingers, drinks from cup

Scribbles

Stacks 2 blocks

Communication:

Uses 1 word\*

Uses 3-10 words

Indicates what he/she wants by pulling, pointing or grunting

Understands simple commands

Points to pictures in book

Social:

Gives and takes food or toys

Throws objects in play

Listens to a story

Comments:

\*Absence of these milestones= Autism Screen

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Water source:

Public

Well  Tested

Fluoride  Yes  No

Current oral health problems:

Physical Examination:  = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lungs

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, social competence, family relationships, and community interaction

Other:

Assessment:  Well Child  Other diagnosis

Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record

Labs:  Blood lead, if needed or high risk

Referrals:  Developmental  Dentist

Blood lead  $\geq$  10 ug/dl

BTT  CSHCN 1-800-642-9704

Other referral(s)

Follow Up/Next Visit:  18 months of age  Other

Please print Name of Facility or Clinician

Signature of Clinician/Title





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

18 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

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

Caretaker(s) working outside home?  Yes  No  
 Child care?  No  Yes \_\_\_\_\_  
 Other changes since last visit:

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

GROWTH PLOTTED ON GROWTH CHART  
 Normal elimination  Normal sleep patterns  
 Comments:

Nutrition:  Breast feeding; Frequency \_\_\_\_\_  
 Bottle feeding; Amount \_\_\_\_\_ Frequency \_\_\_\_\_  
 Formula \_\_\_\_\_  
 Milk  Juice  Water  Normal eating habits  
 Vitamins \_\_\_\_\_  
 Comments:

Passive Smoking Risk:  Yes  No

Check those that apply  
 Hemoglobin/Hematocrit Risk:  Low risk  High risk  
 See Periodicity Schedule for risk indicators

Tuberculosis Risk:  Low risk  High risk  
 Increased risk of exposure d/t Contacts/Travel/Immigration  
 Radiographic or clinical findings suggestive of TB

Lead Risk:  Low risk  High risk  
 Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

Developmental Surveillance & Screening:  
 Standardized Screening Tool:  
 ASQ3 Other: \_\_\_\_\_  
 Results in chart/record  Yes  No

Autism Screening:  
 Autism Specific Screening Tool:  
 M-CHAT Other: \_\_\_\_\_  
 Results in chart/record  Yes  No

Comments:

Gets along with other family members  Yes  No

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

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

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

Abnormal Findings and Comments:  
 Possible Signs of Abuse  Yes  No

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

Assessment:  Well Child  Other diagnosis  
 Risk indicators reviewed/screen complete

Plan/Referrals:  
 For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations:  UTD  Given, see vaccine record  
 Labs:  Blood lead, if high risk

Referrals:  Developmental  Dentist  
 Blood lead  $\geq$  10 ug/dl  
 BTT  CSHCN 1-800-642-9704  
 Other referral(s)

Follow Up/Next Visit:  24 months of age  Other \_\_\_\_\_

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title





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

24 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History:  Check those that apply

- No change
- Family situation change

Caretaker(s) working outside home?  Yes  No

Child care?  No  Yes \_\_\_\_\_

Other changes since last visit:

Current Health Indicators:  Check those that apply

- No change
- Changes since last visit:

- GROWTH PLOTTED ON GROWTH CHART
- BMI CALCULATED AND PLOTTED ON BMI CHART
- Normal elimination  Normal sleep patterns
- Comments:

Nutrition:  Normal eating habits

Vitamins: \_\_\_\_\_  
Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

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

Dyslipidemia Risk:  Low risk  High risk

- Family history of cardiovascular disease
- Family history of elevated blood cholesterol
- Cigarette smoking  Elevated blood pressure
- Overweight/obesity  Diabetes
- Physical inactivity  Poor dietary habits

Tuberculosis Risk:  Low risk  High risk

- Increased risk of exposure d/t Contacts/Travel/Immigration
- Radiographic or clinical findings suggestive of TB

Lead Risk: Blood lead required at 24 months

Developmental Surveillance:  Check those that apply

- Gross Motor:
- Runs  Walk up and down stairs
  - Kicks ball  Throws ball

- Fine Motor:
- Uses spoon and fork  Opens a door
  - Makes horizontal and circular strokes with crayon
  - Stacks 5-6 blocks

- Communication:
- Uses 2 word phrases  ≥20 word vocabulary
  - Follows two-step commands  Uses pronouns
  - Listens to stories

- Cognitive:
- Hides and finds objects  Pretend play
  - Problem solve

- Social:
- Parallel play with other children
  - Imitates adults

Autism Screening:

Autism Specific Screening Tool:

M-CHAT Other: \_\_\_\_\_

Results in chart/record  Yes  No

Comments:

Ability to separate from parents  Yes  No

Gets along with other family members  Yes  No

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Date of last dental visit \_\_\_\_\_

Water source:

- Public
- Well  Tested
- Fluoride  Yes  No

Current oral health problems:

Physical Examination:  = Normal limits

- General Appearance  Skin
- Neurological  Reflexes
- Head  Neck
- Eyes  Red Reflex  Ocular Alignment
- Ears  Nose  Oral Cavity/Throat
- Lungs  Heart  Pulses
- Abdomen  Genitalia
- Back  Extremities

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

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

Assessment:  Well Child  Other diagnosis

Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

BTT transition planning

Immunizations:  UTD  Given, see vaccine record

Labs:  Blood lead required at 24 months

Referrals:  Developmental  Dentist

- Blood lead ≥ 10 ug/dl
- BTT  CSHCN 1-800-642-9704
- Other referral(s)

Follow Up/Next Visit:  30 months of age  Other

\_\_\_\_\_  
Please print Name of Facility or Clinician

\_\_\_\_\_  
Signature of Clinician/Title



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

30 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ HC \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

History:  No change  
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History:  Check those that apply

- No change
- Family situation change

Caretaker(s) working outside home?  Yes  No

Child care?  No  Yes \_\_\_\_\_

Other changes since last visit:

Current Health Indicators:  Check those that apply

- No change
- Changes since last visit:

- GROWTH PLOTTED ON GROWTH CHART
- BMI CALCULATED AND PLOTTED ON BMI CHART
- Normal elimination  Normal sleep patterns
- Comments:

Nutrition:  Normal eating habits

Vitamins \_\_\_\_\_  
 Comments:

Passive Smoking Risk:  Yes  No

Check those that apply

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

Tuberculosis Risk:  Low risk  High risk

- Increased risk of exposure d/t Contacts/Travel/Immigration
- Radiographic or clinical findings suggestive of TB

Lead Risk:  Low risk  High risk

- Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
- Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
- Has a sibling or playmate who has or did have lead

Developmental Surveillance & Screening:  
 Standardized Screening Tool:

ASQ3 Other: \_\_\_\_\_

Results in chart/record  Yes  No

Comments:

Ability to separate from parents  Yes  No

Gets along with other family members  Yes  No

Appropriate Behavior  Yes  No

Do you think your child sees OK?  Yes  No

Do you think your child hears OK?  Yes  No

Oral Health Screen

Date of last dental visit \_\_\_\_\_

Water source:

- Public
- Well  Tested
- Fluoride  Yes  No

Current oral health problems:

Physical Examination:  = Normal limits

- |   |   |
|---|---|
| <input type="checkbox"/> General Appearance                       | <input type="checkbox"/> Skin               |
| <input type="checkbox"/> Neurological                             | <input type="checkbox"/> Reflexes           |
| <input type="checkbox"/> Head                                     | <input type="checkbox"/> Neck               |
| <input type="checkbox"/> Eyes <input type="checkbox"/> Red Reflex | <input type="checkbox"/> Ocular Alignment   |
| <input type="checkbox"/> Ears <input type="checkbox"/> Nose       | <input type="checkbox"/> Oral Cavity/Throat |
| <input type="checkbox"/> Lungs <input type="checkbox"/> Heart     | <input type="checkbox"/> Pulses             |
| <input type="checkbox"/> Abdomen                                  | <input type="checkbox"/> Genitalia          |
| <input type="checkbox"/> Back                                     | <input type="checkbox"/> Extremities        |

Abnormal Findings and Comments:

Possible Signs of Abuse  Yes  No

Health Education/Anticipatory Guidance:

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

Assessment:  Well Child  Other diagnosis

Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete page 2 on the reverse.

BTT transition planning

Immunizations:  UTD  Given, see vaccine record  
 Labs:

Referrals:  Developmental  Dentist

- Blood lead  $\geq$  10 ug/dl
- BTT  CSHCN 1-800-642-9704
- Other referral(s)

Follow Up/Next Visit:  3 years of age  Other

\_\_\_\_\_  
 Please print Name of Facility or Clinician

\_\_\_\_\_  
 Signature of Clinician/Title





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

3 Year Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/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 years)  
 Do you think your child hears OK?  Yes  No

Wears hearing aids  Yes  No

**Oral Health Screen**

Date of last dental visit \_\_\_\_\_  
 Water source:  Public  Well  Tested  
 Fluoride  Yes  No  
 Current dental problems:

**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  Dentist  Vision  
 Hearing  Blood lead  $10 \geq \mu\text{g/dl}$   CSHCN 1-800-642-9704  
 Other:

Provider signature required for validation <input type="checkbox"/> 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, or visits to other providers:

**Social/Family History:**  Check those that apply

- No change  
 Family situation change

Caretaker(s) working outside home?  Yes  No  
 Child care?  No  Yes \_\_\_\_\_  
 Other changes since last visit:

**Current Health Indicators:**  Check those that apply

- No change  
 Changes since last visit:

School: Grade \_\_\_\_\_  Attends school regularly  N/A  
 Ability to separate from parents \_\_\_\_\_  
 Gets along with other family members

GROWTH PLOTTED ON GROWTH CHART  
 BMI CALCULATED AND PLOTTED ON BMI CHART

- Normal elimination  
 Normal sleep patterns  
 Appropriate behavior

**Nutrition:**  Normal eating habits

- Vitamins \_\_\_\_\_  
 Passive smoking risk  Yes  No

Check those that apply

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

**Tuberculosis Risk:**  Low risk  High risk

- Increased risk of exposure d/t Contacts/Travel/Immigration  
 Radiographic or clinical findings suggestive of TB

**Lead Risk:**  Low risk  High risk

- Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

**Physical Examination:**  Check those that apply

- |   |   |
|---|---|
| <input type="checkbox"/> General Appearance | <input type="checkbox"/> Skin               |
| <input type="checkbox"/> Neurological       | <input type="checkbox"/> Reflexes           |
| <input type="checkbox"/> Head               | <input type="checkbox"/> Neck               |
| <input type="checkbox"/> Eyes               | <input type="checkbox"/> Red Reflex         |
| <input type="checkbox"/> Nose               | <input type="checkbox"/> Ears               |
| <input type="checkbox"/> Lungs              | <input type="checkbox"/> Heart              |
| <input type="checkbox"/> Abdomen            | <input type="checkbox"/> Ocular Alignment   |
| <input type="checkbox"/> Back               | <input type="checkbox"/> Oral Cavity/Throat |
|   | <input type="checkbox"/> Pulses             |
|   | <input type="checkbox"/> Genitalia          |
|   | <input type="checkbox"/> Extremities        |

**Abnormal Findings and Comments:**

Possible signs of abuse  Yes  No

**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  
 Other:

**Assessment:**  Well Child  Other diagnosis

**Plan/Referrals:**

For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs:  Blood lead, if needed or high risk

Referrals: see manual for automatic referrals  
 Other referral(s)

Follow Up/Next Visit:  4 years of age  Other





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

4 Year Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/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 (obj)  
25 db@ \_\_\_\_\_ 20 db@ \_\_\_\_\_  
R ear: \_\_\_\_\_ 500HZ R ear: \_\_\_\_\_ 1000HZ \_\_\_\_\_ 2000HZ \_\_\_\_\_ 4000HZ  
L ear: \_\_\_\_\_ 500HZ L ear: \_\_\_\_\_ 1000HZ \_\_\_\_\_ 2000HZ \_\_\_\_\_ 4000HZ  
 Unable to obtain, re-screen in 4-6 months  
Wears hearing aids  Yes  No

**Oral Health Screen**  
Date of last dental visit \_\_\_\_\_  
Water source:  Public  Well  Tested  
Fluoride  Yes  No  
 Current dental problems:

**Developmental Surveillance:** Check those that apply  
**Gross Motor:**  
 Walks, climbs, runs  Hops, jumps on 1 foot  
 Up/down stairs alternating feet, without support  
 Throws overhand  Rides bicycle with training wheels  
**Fine Motor:**  
 Builds 10 block tower  Uses utensils  Has manual dexterity  
 Draws 3 part person  Puts on/removes clothes  
**Communication:**  
 Uses past tense  Talks about daily experiences  
 Speaks intelligibly  Uses 4-5 word sentences  
 Short paragraphs  May show some lack of fluency  
**Cognitive:**  Names 4 colors  Aware of gender (self and others)  
 Knows difference between fantasy and reality  
**Social:**  Listens to stories  Can sing a song  
 Plays interactive games with peers  Elaborate fantasy play

**Immunizations:** Attach current immunization record  
 UTD  Given, see vaccine record  
**Referrals:**  Developmental  Dentist  Vision  
 Hearing  Blood lead 10<sub>≥</sub>ug/dl  CSHCN 1-800-642-9704  
 Other:

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, or visits to other providers:

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

Caretaker(s) working outside home?  Yes  No  
Child care?  No  Yes \_\_\_\_\_  
Other changes since last visit:

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

School: Grade \_\_\_\_\_  Attends school regularly  N/A  
 Ability to separate from parents \_\_\_\_\_  
 Gets along with other family members

GROWTH PLOTTED ON GROWTH CHART  
 BMI CALCULATED AND PLOTTED ON BMI CHART

Normal elimination  
 Normal sleep patterns  
 Appropriate behavior

**Nutrition:**  Normal eating habits  
 Vitamins \_\_\_\_\_  
 Passive smoking risk  Yes  No

Check those that apply  
**Hemoglobin/Hematocrit Risk:**  Low risk  High risk  
*See Periodicity Schedule for risk indicators*

**Dyslipidemia Risk:**  Low risk  High risk  
*See Periodicity Schedule for risk indicators*

**Tuberculosis Risk:**  Low risk  High risk  
*See Periodicity Schedule for risk indicators*

**Lead Risk:**  Low risk  High risk  
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

**Physical Examination:**  Check those that apply  
 General Appearance  Skin  
 Neurological  Reflexes  
 Head  Neck  
 Eyes  Red Reflex  Ocular Alignment  
 Nose  Ears  Oral Cavity/Throat  
 Lungs  Heart  Pulses  
 Abdomen  Genitalia

**Abnormal Findings and Comments:**  
Possible signs of abuse  Yes  No

**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  
Other:

**Assessment:**  Well Child  Other diagnosis

**Plan/Referrals:**  
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs:  Blood lead, if needed or high risk

Referrals: see manual for automatic referrals  
 Other referral(s)

Follow Up/Next Visit:  5 years of age  Other





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

5 Year Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

Health conditions that may require care at school: \_\_\_\_\_

Vision Acuity Screen (obj) R \_\_\_\_\_ L \_\_\_\_\_  
Wears glasses  Yes  No

Hearing Screen (obj)  
25 db@ \_\_\_\_\_ 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 dental problems:

Developmental Surveillance:  Check those that apply  
Gross Motor:  
 Walks, climbs, runs  May be able to skip

Up/down stairs alternating feet, without support  
Fine Motor:  
 Copies ▲ or ■  Prints some letters  
 Draws figure w/head, arms and legs  Dresses self  
 Has manual dexterity  
Communication:  
 Able to recall parts of story  Fluent speech  
 Uses complete sentences  Speaks in short sentences  
 Uses future tense  Second language spoken at home  
Cognitive:  
 Knows address and phone #  Can count on fingers  
 Follows 2-3 step instructions  
 Recognizes many letters of the alphabet  
Social:  
 Listens to stories  Follows rules  
 Plays interactive games with peers  
 Elaborate fantasy play/make believe/dress up

**Immunizations:** Attach current immunization record  
 UTD  Given, see vaccine record  
**Referrals:**  Developmental  Dentist  Vision  
 Hearing  Blood lead 10<sub>2</sub>ug/dl  CSHCN 1-800-642-9704  
 Other:

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, or visits to other providers:

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

Caretaker(s) working outside home?  Yes  No  
Child care?  No  Yes \_\_\_\_\_  
Other changes since last visit:

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

School: Grade \_\_\_\_\_  Attends school regularly  N/A  
 Ability to separate from parents \_\_\_\_\_  
Likes most about school \_\_\_\_\_  
Likes least about school \_\_\_\_\_  
 Gets along with other family members

GROWTH PLOTTED ON GROWTH CHART  
 BMI CALCULATED AND PLOTTED ON BMI CHART  
 Normal elimination  
 Normal sleep patterns  
 Appropriate behavior

**Nutrition:**  Normal eating habits  
 Vitamins \_\_\_\_\_  
 Passive smoking risk  Yes  No

Check those that apply  
**Hemoglobin/Hematocrit Risk:**  Low risk  High risk  
*See Periodicity Schedule for risk indicators*

**Tuberculosis Risk:**  Low risk  High risk  
 Increased risk of exposure d/t Contacts/Travel/Immigration  
 Radiographic or clinical findings suggestive of TB

**Lead Risk:**  Low risk  High risk  
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

**Physical Examination:**  Check those that apply  
 General Appearance  Skin  
 Neurological  Reflexes  
 Head  Neck  
 Eyes  Red Reflex  Ocular Alignment  
 Nose  Ears  Oral Cavity/Throat  
 Lungs  Heart  Pulses  
 Abdomen  Genitalia  
 Back  Extremities

**Abnormal Findings and Comments:**  
Possible signs of abuse  Yes  No

**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  
Other:

Assessment:  Well Child  Other diagnosis

**Plan/Referrals:**  
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs:  Blood lead, if needed or high risk

Referrals: see manual for automatic referrals  
 Other referral(s)

Follow Up/Next Visit:  6 years of age  Other



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

6 Year Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Screen Date \_\_\_\_\_

Allergies:  NKDA \_\_\_\_\_ Current Meds:  None \_\_\_\_\_

Accompanied by:  Parent  Grandparent  Foster parent/organization  Other \_\_\_\_\_

Health conditions that may require care at school: \_\_\_\_\_

Vision Acuity Screen (obj) R \_\_\_\_\_ L \_\_\_\_\_  
Wears glasses  Yes  No

Hearing Screen (obj)  
25 db@ \_\_\_\_\_ 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 dental problems:

**Developmental Surveillance:** ✓ Check those that apply  
Gross Motor:  
 Backwards tandem walk  
 Balances on each foot with eyes closed-smooth transition  
Fine Motor:  
 Ties shoes  Draws picture of family  
Communication:  
 Fluent speech  Uses complete sentences  
Cognitive:  
 Knows name and address  Knows emergency phone number  
 Prints name  Prints alphabet  
Social:  
 Anger control  Follows rules

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

Referrals:  Developmental  Dentist  Vision  
 Hearing  Blood lead 10<sub>≥</sub>ug/dl  CSHCN 1-800-642-9704  
 Other:

*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, or visits to other providers:

**Social/Family History:** ✓ Check those that apply  
 No change  Family situation change  
Caretaker(s) working outside home?  Yes  No  
Child care?  No  Yes \_\_\_\_\_  
Other changes since last visit:

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

**Nutrition:**  Normal eating habits  
 Vitamins \_\_\_\_\_  
 Passive smoking risk  Yes  No  
 GROWTH PLOTTED ON GROWTH CHART  
 BMI CALCULATED AND PLOTTED ON BMI CHART  
 Normal elimination  Normal sleep patterns

✓ Check those that apply  
**Hemoglobin/Hematocrit Risk:**  Low risk  High risk  
See Periodicity Schedule for risk indicators

**Dyslipidemia Risk:**  Low risk  High risk  
See Periodicity Schedule for risk indicators

**Tuberculosis Risk:**  Low risk  High risk  
See Periodicity Schedule for risk indicators

**Lead Risk:**  Low risk  High risk  
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?

**Behavior:** ✓ Check those that apply  
Behavior appropriate:  Yes  No  
Fun activities:  Yes  No  
Friends:  Yes  No  
Feelings:  Content  Sad  Angry  Down/depressed  
 Thoughts/plans to harm  Self  Others  Animals  
 Trouble at school  Trouble with the law

**Risk Indicators:** ✓ Check those that apply  None identified  
 Poor self image  Lack of physical activity  
 Weight or height concerns? \_\_\_\_\_  
 Peer pressure to do things you don't want to do:

\_\_\_\_\_  Does not wear protective gear, including seats belts  
 Access to firearms  Has a firearm  
 Witnessed violence  Threatened with violence  
 Excessive television/video game use (> 2 hrs. per day)  
School: Grade \_\_\_\_\_  Attends school regularly  N/A  
 Ability to separate from parents \_\_\_\_\_  
Likes most about school \_\_\_\_\_  
Likes least about school \_\_\_\_\_  
Family:  Gets along with other family members  
If you could, how would you change your family/home?

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

**Abnormal Findings and Comments:**  
Possible signs of abuse:  Yes  No

**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  
Other:

**Assessment:**  Well Child  Other diagnosis

**Plan/Referrals:**  
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs:  Blood lead, if needed or high risk  
Referrals: see manual for automatic referrals  
 Other referral(s)

Follow Up/Next Visit:  7 years of age  Other

