3 yr.

3 Year Form

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

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 (abj) 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≥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

School Entry Requirements

The information above this line is intended to be released to meet 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

Parents working outside home? ◻ Mother ◻ Father
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*
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 the Medical Necessity Form 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

4 yr.

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≥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

School Entry Requirements

The information above this line is intended to be released to meet 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

Parents working outside home? ◻ Mother ◻ Father
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*
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
◻ 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 the Medical Necessity Form 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

5 yr.

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≥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

School Entry Requirements

The information above this line is intended to be released to meet 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

Parents working outside home? ◻ Mother ◻ Father
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*
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 the Medical Necessity Form 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