New Requirements for 7th Grade for the 2017-2018 School Year

Starting in 2017, the West Virginia Department of Education Policy 2423 requires all students in 7th grade to have the following on file, **prior** to the first day of school:

1. **Tdap & Meningitis Vaccine**

2. **Oral Health Exam** signed and dated by the student's dentist within the last 12 calendar months. You may use the attached oral health form or you can provide a form from your dentist.

3. **Well Child Check-Up** signed and dated by the student's physician within the last 12 calendar months. You may use the attached well child form or an electronic health record of the exam from your physician.

If you have any questions, please see your school nurse.

Sincerely,

Certified School Nurse
Harrison County Board of Education

Student Name__________________________________ DOB: ___________________

7th Grade Requirement	**Date Administered:**	**Initials:**
• Tdap (1 dose)	__________________	_______
• Meningococcal (1 dose)	__________________	_______

**There are no provisional enrollments permitted for the 7th grade requirements.*

Students **MUST** show proof of these vaccinations to enter 7th grade. Please take your students to their health care provider for these required vaccinations with this form. If your student has already received these vaccinations, please attach them to this form and return to school nurse.

Physician Name____ Phone Number____________________
Address____

Physician Signature____

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

11, 12, 13 and 14 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 ____________________

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 ☐ LMP__________ ☐ N/A
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
Dyslipidemia Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

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

☐ **Behavior/Mental Health Screen:** *✓ Check those that apply*
Appropriate behavior: ☐ Yes ☐ No
Fun activities: ____________________
____
Friend(s): ☐ Yes ☐ No
Concern(s): ☐ Yes ☐ No
Feelings: ☐ Content
☐ Sad ☐ Less than a week ☐ More than a week
☐ Angry ☐ Less than a week ☐ More than a week
☐ Down/depressed ☐ Less than a week ☐ More than a week
☐ Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals
☐ Trouble at school ☐ Trouble with the law

Behavioral concerns/comments: ☐ Yes ☐ No

Risk indicators: *✓ Check those that apply* ☐ None identified
☐ Poor self image ☐ Lack of physical activity
☐ Weight or height concerns____________________
☐ Tobacco use: ☐ Cigarettes/# per day__________ ☐ Chew
☐ Alcohol use__________ ☐ Other drug __________
☐ Peer pressure to do things you don't want to do:
____
☐ Pressure to have sex ☐ Inappropriate touching
☐ Does not wear protective gear, including seat 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
☐ Special classes____________________
Likes most about school:____________________
____
Likes least about school: ____________________
____
Proud of:____________________
____
Participates in activities____________________
Plans after high school____________________

Family/Sexuality:
☐ Gets along with other family members
If you could, how would you change your life?
____
home? ____________________
family?____________________

☐ Sex education/questions
Sexually active? ☐ Yes ☐ No STIs__________ ☐ N/A
Method of contraception__________ ☐ N/A

☐ **Vision Acuity Screen** (Obj @ 12 yrs) R______ L______

☐ **Hearing Screen** as indicated by risk screen: 20db@
R ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit____________________
☐ Current oral health problems:

Physical Examination: *✓= Normal limits*
☐ General Appearance ☐ Skin
☐ Neurological ☐ Reflexes
☐ Head ☐ Neck
☐ Eyes ☐ 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, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, family relationships and community interaction, school achievement, health care transition from adolescence to adulthood in the medical home (beginning at 14 years)
Other:

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

Plan/Referrals:
For treatment plans requiring authorization, please complete the Medical Necessity Form on the reverse.

Immunizations: ☐ **UTD** ☐ Given, see vaccine record
Labs:

Referrals*: ☐ Behavioral/Mental health ☐ Dentist ☐ Vision
☐ Hearing ☐ CSHCN **1-800-642-9704**
See Provider Manual for automatic referrals
☐ Other referral(s)

Follow Up/Next Visit: ☐ 12 years of age ☐ 13 years of age
☐ 14 years of age ☐ 15 years of age ☐ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

Student Oral Health Form

Patient Information

Child's Name (Last, First, MI) ______ Date of Birth (MM/DD/YYYY) ______ Age ______

Address ______ City ______ State ______ Zip Code ______

Guardian ______ Phone ______

Oral Health Service

Please provide date of service in applicable box below:

	School Entry	2nd Grade	7th Grade	12th Grade
Date of service				

Current Oral Health Services:
Type of Services Provided? ☐ Examination

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Additional Information

______

______

______

______

Oral Health Provider's Contact Information and Signature

Provider Name (please print) ______ Phone Number ______ Fax Number ______

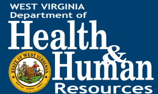
Practice Name ______ Address ______

Provider Signature ______ Office Contact email ______

ATTENTION School Health Checkpoints for Grades 7 & 12

Students in WV Public Schools Will Need:

- Annual HealthCheck/physical examination from a doctor/medical provider
- Dental examination from a dentist; and
- Already required adolescent vaccinations (Tdap and Meningitis shots).



West Virginia DEPARTMENT OF EDUCATION