

Screen Date _____

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

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 (apply every 3 to 6 months)

Yes No _____

Vision Acuity Screen:

R _____ L _____ UTO (retest in 6 months)

Wears glasses? Yes No

Hearing Screen

20 db@ _____ UTO (retest in 6 months)

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 enter bathroom and have a bowel movement by himself/herself

Child can brush his/her teeth Child can dress and undress without much help

Child can engage in well-developed imaginative play Child can answer simple questions Child can speak in words that are 100% understandable to strangers

Child can draw pictures that you recognize Child can follow simple rules when playing games

Child can tell you a story from a book

Child can skip on 1 foot Child can climb stairs, alternating feet, without support

Child can draw a person with at least 3 body parts

Child can draw a simple cross Child can unbutton and button medium sized buttons

Child can grasp pencil with thumb and fingers instead of fist

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

Women, Infants and Children (WIC) **1-304-558-0030**

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 _____

Is your child in school? Yes No _____

Favorite thing about school _____

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

Excessive television/video game/internet/cell phone use

General Health

Growth plotted on growth chart

BMI calculated and plotted on BMI chart

SAMPLE FORM

This form may be used or a similar form from your physician's office. Must be signed and dated by doctor within the last 365 days.