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 Wt_____ Ht_____ BMI_____ BP_____ Pulse_____ Temp_____

Allergies: □ NKDA _____ Current Meds: □ None_____

Accompanied by: □ Parent □ Grandparent □ Foster parent □ Foster 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
Wears hearing aids □ Yes □ No

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

Developmental

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 □ Emotional □ Dentist □ Vision
□ Hearing □ Blood lead 10≥ug/dl □ CSHCN **1-800-642-9704**

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

SAMPLE FORM

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

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Social Emotional Health/Interpersonal Trauma[1]

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

_____
Has your child lived anywhere but with parent(s)/caretaker(s)?
□ Yes □ No _____
Parent(s)/Caretaker(s) working outside home? □ Yes □ No
Child care? □ Yes □ No _____
Ability to separate from parent(s)/caretaker(s)? □ Yes □ No
Sibling(s) in the home? □ Yes □ No _____
Gets along with other family members? □ Yes □ No

Social Emotional/Stress Indicators: ✓ *Check those that apply*
Is there stress in the home? □ Yes □ No

_____
Has your child ever had a really scary or bad experience that they cannot forget? □ Yes □ No _____
Does your child have bad dreams or nightmares? □ Yes □ No

_____
Has your child experienced an emotional loss? □ Yes □ No

_____

Risk Indicators: ✓ *Check those that apply*
Exposure to: □ Passive Smoke □ Cigarettes □ E-Cigs □ Chew
□ Alcohol □ Other drugs_____
□ Access to weapon(s) □ Has a weapon(s)
Do you utilize a car/booster seat for your child □ Yes □ No
□ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____

Pre-school □ Yes □ No
□ Attends school regularly _____ □ NA
□ Special classes_____ □ NA
□ Participates in extracurricular activities_____

Physical Health

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

Nutrition: □ Normal eating habits □ Vitamins_____

□ Normal elimination □ Normal sleep patterns

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?

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

Physical Examination: ✓ = *Normal limits*

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

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

Assessment: □ **Well Child** □ **Other Diagnosis**

Labs: □ Blood lead, if needed or high risk

Referrals: *see above* □ Other

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: □ 5 years of age □ Other

[1] Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.
For assistance phone 844-HELP4WV (844-435-7498).