

Screen Date _____

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 _____ 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 _____
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 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 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

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 Trauma¹

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 wear protective gear, including seat belts? Yes No

Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____

Pre-school School/Grade _____
 Attends school regularly _____

Special classes _____
 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
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
 Back Extremities
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: 6 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).