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

6 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:
□ Backwards tandem walk
□ Balances on each foot with eyes closed-smooth transition
Fine Motor:
□ Ties shoes □ Draws picture of family
Communication:
□ Fluent speech □ Uses complete sentences
Cognitive:
□ Knows name and address □ Knows emergency phone number
□ Prints name □ Prints alphabet
Social:
□ Anger control □ Follows rules

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

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, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change □ Family situation change
Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes _____
Other changes since last visit:

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

Nutrition: □ Normal eating habits
□ Vitamins_____
□ Passive smoking risk □ Yes □ No
□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns

✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

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?

□ **Behavior:** ✓ *Check those that apply*
Behavior appropriate: □ Yes □ No
Fun activities: □ Yes □ No
Friends: □ Yes □ No
Feelings: □ Content □ Sad □ Angry □ Down/depressed
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law

Risk Indicators: ✓ *Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns?_____
□ Peer pressure to do things you don't want to do:
_____
□ Does not wear protective gear, including seats 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 □ N/A
□ Ability to separate from parents_____
Likes most about school_____
Likes least about school_____
Family: □ Gets along with other family members
If you could, how would you change your family/home?

Physical Examination: ✓ = *Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eye □ 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 page 2 on the reverse.

Labs: □ Blood lead, if needed or high risk
Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 7 years of age □ Other

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH