Screen Date____________________

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

4 Year Form

Name____________________ DOB____________ Age________ Sex: ☐ M ☐ F **Race/Ethnicity**____________

Weight ________ Height________ BMI________ Pulse________ BP________ Resp________ Temp________ Pulse Ox (*optional*)________

Allergies ☐ NKDA ____________________

Current meds ☐ None____________________

☐ Foster Child ____________ ☐ Kinship Placement ____________ ☐ 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
☐ **Family health history reviewed** ____________
____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No ____________
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:____________
____
____

Psychosocial/Behavioral

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 ____________
____

Is your child in school? ☐ Yes ☐ No ____________
Favorite thing about school____________
Any problems?____________
Activities outside school____________
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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____________
____

Continue on page 2

Name______________________________ DOB____________________ Age____________ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- ☐ Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

____
____
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____
____
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____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day____________________
☐ Vitamins______________________________
☐ Normal elimination______________________________
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise ____________________
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?____________________

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Lead Risk**	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Dyslipidemia Risk**	☐ Low risk	☐ High risk
***Hepatitis B Risk**	☐ Low risk	☐ High risk

See Periodicity Schedule for Risk Factors

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	____________
Skin	☐ N	☐ Abn	____________
Neurological	☐ N	☐ Abn	____________
Reflexes	☐ N	☐ Abn	____________
Head	☐ N	☐ Abn	____________
Neck	☐ N	☐ Abn	____________
Eyes	☐ N	☐ Abn	____________
Red Reflex	☐ N	☐ Abn	____________
Ocular Alignment	☐ N	☐ Abn	____________
Ears	☐ N	☐ Abn	____________
Nose	☐ N	☐ Abn	____________
Oral Cavity/Throat	☐ N	☐ Abn	____________
Lung	☐ N	☐ Abn	____________
Heart	☐ N	☐ Abn	____________
Pulses	☐ N	☐ Abn	____________
Abdomen	☐ N	☐ Abn	____________
Genitalia	☐ N	☐ Abn	____________
Back	☐ N	☐ Abn	____________
Hips	☐ N	☐ Abn	____________
Extremities	☐ N	☐ Abn	____________

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, School Readiness, Developing Healthy Nutrition and Personal Habits, Media Use, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Labs

☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other ______________________________
____

Referrals

See page 1, school requirements

Medical Necessity

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.

Follow Up/Next Visit ☐ 5 years of age
☐ Other______________________________

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature