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_____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:
□ 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 □ 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

Parents working outside home? □ Mother □ Father
Child care? □ No □ Yes _____
Other changes since last visit:

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

School: Grade_____□ Attends school regularly □ N/A
□ Ability to separate from parents _____
Likes most about school_____
Likes least about school_____
□ Gets along with other family members

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination
□ Normal sleep patterns
□ Appropriate behavior

Nutrition: □ Normal eating habits
□ Vitamins_____
□ Passive smoking risk □ Yes □ No

✓ *Check those that apply*
Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

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?

Physical Examination: ✓ *Check those that apply*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head		□ Neck
□ Eyes	□ Red Reflex	□ 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 the Medical Necessity Form on the reverse.

Labs: □ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 6 years of age □ Other