West Virginia Department of Health and Human Resources

3 Year Form

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

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 *(Subjective screen required at 3)*
Do you think your child hears okay? ◻ Yes ◻ No
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: ◻ Jumps in place ◻ Kicks ball ◻ Rides tricycle
◻ Up/down stairs alternating feet
Fine Motor: ◻ Uses cup, spoon and fork ◻ Has manual dexterity
◻ Builds a tower with 6 or 8 cubes ◻ Copies a circle
Communication: ◻ Speaks intelligibly
◻ Uses 3-4 word sentences ◻ Short paragraphs
◻ Uses plurals and pronouns
Cognitive: ◻ Follows 2 step instructions
◻ Aware of gender (of self and others)
◻ Knows name, age and sex ◻ Names most common objects
Social: ◻ Listens to stories ◻ Shows early imaginative behavior
◻ Plays interactive games with peers (able to take turns)

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 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_____
Are there weapon(s)in the home? ◻ Yes ◻ No
Are the weapon(s)secured? ◻ Yes ◻ No ◻ NA
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
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: ◻ 4 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).