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

3 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_____
□ Unable to obtain, re-screen in 4-6 month

Wears glasses □ Yes □ No

□ **Hearing Screen** (Subjective screen required at 3 years)
Do you think your child hears OK? □ Yes □ No

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:
□ 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 □ 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:

School: Grade_____□ Attends school regularly □ N/A
□ Ability to separate from parents_____
□ 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*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

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 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: □ 4 years of age □ Other