



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

4 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 (obj)
25 db@ _____ 20 db@ _____
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
 Unable to obtain, re-screen in 4-6 months
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 Hops, jumps on 1 foot
 Up/down stairs alternating feet, without support
 Throws overhand Rides bicycle with training wheels
Fine Motor:
 Builds 10 block tower Uses utensils Has manual dexterity
 Draws 3 part person Puts on/removes clothes
Communication:
 Uses past tense Talks about daily experiences
 Speaks intelligibly Uses 4-5 word sentences
 Short paragraphs May show some lack of fluency
Cognitive: Names 4 colors Aware of gender (self and others)
 Knows difference between fantasy and reality
Social: Listens to stories Can sing a song
 Plays interactive games with peers Elaborate fantasy play

Immunizations: Attach current immunization record
 UTD Given, see vaccine record
Referrals: Developmental Dentist Vision
 Hearing Blood lead $10 \geq \mu\text{g}/\text{dl}$ 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

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?

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

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: 5 years of age Other