

Screen Date _____

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

5 and 6 Year Form

Name _____ DOB _____ Age _____ Sex: M F

Weight _____ Height _____ BMI _____ Pulse _____ BP _____ Resp _____ Temp _____ Pulse Ox (optional) _____

Allergies NKDA _____

Current meds None _____

Foster Child 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 (5 years, apply every 3 to 6 months)

Yes No _____

Vision Acuity Screen:

R _____ L _____

Wears glasses? Yes No

Hearing Screen

20 db@

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 balance on one foot, hops and skips

Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles

Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors

Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance

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

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

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: _____

Family health history reviewed _____

Concerns and/or questions _____

Social/Psychosocial History

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 _____

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 _____

Child's grade in school _____

Favorite subject _____

Any problems? _____

Activities outside school _____

Peer relationships/friends Good Okay Poor

Risk Indicators (✓ Check those that apply)

Child exposed to Cigarettes E-Cigarettes 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

Does your child wear protective gear, including seat belts?

Yes No

Excessive television/video game/internet/cell phone use

General Health

Growth plotted on growth chart

BMI calculated and plotted on BMI chart

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