Screen Date____________________

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

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 *(apply every 3 to 6 months)*
☐ Yes ☐ No ______________

Vision Acuity Screen:
R __________ L __________ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen *(Subjective screen required)*
Do you think your child hears okay? ☐ Yes ☐ No
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and urinate by himself/herself ☐ Child can put on coat, jacket or shirt by themselves ☐ Child can eat independently ☐ Child can engage in imaginative play ☐ Child can play in cooperation and share ☐ Child can use 3 word sentences ☐ Child can speak in words that are 75% understandable to strangers ☐ Child can tell you a story from a book or TV ☐ Child can compare things using words like bigger or shorter ☐ Child can understand simple prepositions, such as on or under ☐ Child can pedal a tricycle ☐ Child can climb on and off couch or chair ☐ Child can jump forward ☐ Child can draw a single circle ☐ Child can draw a person with head and 1 other body part ☐ Child can cut with child scissors

☐ 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
☐ Women, Infants and Children (WIC) **1-304-558-0030**

____
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______________
____

Is your child in school? ☐ Yes ☐ No ______________
Favorite thing about school______________
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
☐ 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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West Virginia Department of Health & Human Resources Bureau for Public Health