

Screen Date _____

West Virginia Department of Health and Human Resources

4 Year Form

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 (obj)
 25 db@ _____ 20 db@ _____
 R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
 L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
 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:

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 Trauma¹

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 ☐ NoChild care? ☐ Yes ☐ No _____Ability to separate from parent(s)/caretaker(s)? ☐ Yes ☐ NoSibling(s) in the home? ☐ Yes ☐ No _____Gets along with other family members? ☐ Yes ☐ NoSocial Emotional/Stress Indicators: ☒ Check those that applyIs there stress in the home? ☐ Yes ☐ NoHas your child ever had a really scary or bad experience that they cannot forget? ☐ Yes ☐ NoDoes your child have bad dreams or nightmares? ☐ Yes ☐ NoHas your child experienced an emotional loss? ☐ Yes ☐ No**Developmental**Developmental Surveillance: ☒ Check those that applyGross Motor: ☐ Walks, climbs, runs ☐ Hops, jumps on 1 foot☐ Up/down stairs alternating feet, without support☐ Throws overhand ☐ Rides bicycle with training wheelsFine Motor: ☐ Builds 10 block tower ☐ Uses utensils☐ Has manual dexterity ☐ Draws 3 part person☐ Puts on/removes clothesCommunication: ☐ Uses past tense ☐ Talks about daily experiences☐ Speaks intelligibly ☐ Uses 4-5 word sentences☐ Short paragraphs ☐ May show some lack of fluencyCognitive: ☐ Names 4 colors ☐ Aware of gender (self and others)☐ Knows difference between fantasy and realitySocial: ☐ Listens to stories ☐ Can sing a song☐ Plays interactive games with peers ☐ Elaborate fantasy playRisk Indicators: ☒ Check those that applyExposure to: ☐ Passive Smoke ☐ Cigarettes ☐ E-Cigs ☐ Chew☐ Alcohol ☐ Other drugs _____☐ Access to weapon(s) ☐ Has a weapon(s)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 patternsLead 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?

Immunizations: Attach current immunization record

☐ UTD ☐ Given, see vaccine recordReferrals: ☐ Developmental ☐ Emotional ☐ Dentist ☐ Vision☐ Hearing ☐ Blood lead 10µg/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.

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: ☐ Low risk ☐ High riskDyslipidemia Risk: ☐ Low risk ☐ High riskTuberculosis Risk: ☐ Low risk ☐ High riskPhysical Examination: ☒ = Normal limits☐ General Appearance☐ Neurological☐ Head☐ Eyes☐ Nose☐ Lungs☐ Abdomen

Possible Signs of Abuse

☐ Skin☐ Reflexes☐ Neck☐ Ocular Alignment☐ Oral Cavity/Throat☐ Pulses☐ Genitalia☐ 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 DiagnosisLabs: ☐ Blood lead, if needed or high riskReferrals: 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: ☐ 5 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).

Screen Date _____

West Virginia Department of Health and Human Resources

5 Year Form

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 _____
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
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: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 Trauma¹**Social/Family: ☒ Check those that apply
☐ Family situation change ☐ No changeHas your child lived anywhere but with parent(s)/caretaker(s)?
☐ Yes ☐ NoParent(s)/Caretaker(s) working outside home? ☐ Yes ☐ No
Child care? ☐ Yes ☐ NoAbility to separate from parent(s)/caretaker(s)? ☐ Yes ☐ No
Sibling(s) in the home? ☐ Yes ☐ NoGets along with other family members? ☐ Yes ☐ NoSocial Emotional/Stress Indicators: ☒ Check those that apply
Is there stress in the home? ☐ Yes ☐ NoHas your child ever had a really scary or bad experience that they
cannot forget? ☐ Yes ☐ NoDoes your child have bad dreams or nightmares? ☐ Yes ☐ NoHas your child experienced an emotional loss? ☐ Yes ☐ No**Developmental**Developmental Surveillance: ☒ Check those that apply
Gross Motor: ☐ Walks, climbs, runs ☐ May be able to skip
☐ Up/down stairs alternating feet, without support
Fine Motor: ☐ Copies ▲ or ■ ☐ Prints some letters
☐ Draws figure w/head, arms and legs ☐ Dresses self
☐ Has manual dexterity
Communication: ☐ Able to recall parts of story ☐ Fluent speech
☐ Uses complete sentences ☐ Speaks in short sentences
☐ Uses future tense ☐ Second language spoken at home
Cognitive: ☐ Knows address and phone # ☐ Can count on fingers
☐ Follows 2-3 step instructions
☐ Recognizes many letters of the alphabet
Social: ☐ Listens to stories ☐ Follows rules
☐ Plays interactive games with peers
☐ Elaborate fantasy play/make believe/dress upRisk Indicators: ☒ Check those that applyExposure to: ☐ Passive Smoke ☐ Cigarettes ☐ E-Cigs ☐ Chew
☐ Alcohol ☐ Other drugs _____
☐ Access to weapon(s) ☐ Has a weapon(s)
Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
☐ Pre-school ☐ School/Grade _____
☐ Attends school regularly _____
☐ Special classes _____
☐ 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 patternsLead 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?Immunizations: Attach current immunization record
☐ UTD ☐ Given, see vaccine recordReferrals: ☐ Developmental ☐ Emotional ☐ Dentist ☐ Vision
☐ Hearing ☐ Blood lead 10₂ug/dl ☐ CSHCN 1-800-642-9704Provider signature required for validation
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meet school entry requirements.*

See Periodicity Schedule for risk indicators

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Tuberculosis Risk: ☐ Low risk ☐ High riskPhysical 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 interactionAssessment: ☐ Well Child ☐ Other DiagnosisLabs: ☐ Blood lead, if needed or high riskReferrals: (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/healthcheckFollow Up/Next Visit: ☐ 6 years of age ☐ Other

School Entry Requirements

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