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≥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

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

West Virginia Department of Health & Human Resources Bureau for Public Health