

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

UTID 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

Continue on page 2



Screen Date _____

5 and 6 Year Form, Page 2

Name _____ DOB _____ Age _____ Sex: M F

Nutrition/Physical Activity/Sleep

- Normal eating habits? Yes No
- Fruits/Vegetables/Lean protein per day _____
- Vitamins _____
- Normal elimination _____
- Physical activity/exercise an hour most days
- Type of physical activity/exercise _____
- Normal sleeping patterns? Yes No
- Hours of sleep each night? _____

***See Periodicity Schedule for Risk Factors**

- *Anemia Risk (Hemoglobin/Hematocrit)**
- Low risk High risk

- *Lead Risk**
- Low risk High risk

- *Tuberculosis Risk**
- Low risk High risk

- *Dyslipidemia Risk (year 6)**
- Low risk High risk

Physical Examination (N=Normal, Abn=Abnormal)

- General Appearance N Abn _____
- Skin N Abn _____
- Neurological N Abn _____
- Reflexes N Abn _____
- Head N Abn _____
- Neck N Abn _____
- Eyes N Abn _____
- Ocular Alignment N Abn _____
- Ears N Abn _____
- Nose N Abn _____
- Oral Cavity/Throat N Abn _____
- Lung N Abn _____
- Heart N Abn _____
- Pulses N Abn _____
- Abdomen N Abn _____
- Genitalia N Abn _____
- Back N Abn _____
- Hips N Abn _____
- Extremities N Abn _____

- Possible Signs of Abuse Yes No

Concerns and/or questions _____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information <https://brightfutures.aap.org>)

Social Determinants of Health

- Neighborhood and family violence
- Food security
- Family substance use (tobacco, alcohol, drugs)
- Emotional security and self-esteem
- Connectedness with family

Developmental and Mental Health

- Family rules and routines
- Concern and respect for others
- Patience and control over anger

School

- Readiness
- Established routines and school attendance
- Friends
- After school care
- Parent -teacher communication

Physical Growth and Development

- Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
- Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, healthy foods in school)
- Physical activity (60 minutes per day)

Safety

- Car safety
- Outdoor safety
- Water safety
- Sun protection
- Harm from adults (sexual abuse)
- Home fire safety
- Firearm safety

Other _____

Plan of Care

Assessment Well Child Other Diagnosis

Labs

- Hemoglobin/hematocrit (if high risk)
- Blood lead (if not completed at 12 and/or 24 months or high risk) (enter into WVS/IS)
- TB skin test (if high risk)
- Lipid profile (year 6, if high risk)
- Other _____

Referrals

See page 1, school requirements

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhr.wv.gov/healthcheck

- Follow Up/Next Visit 6 years of age 7 years of age
- Other _____

Screen has been reviewed and is complete

See page 1, school requirements for required signature