Screen Date _____

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

7 and 8 Year Form

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 _____

Immunizations: Attach current immunization record
◻ **UTD** ◻ Given, see vaccine record

◻ **Vision Acuity Screen** *(Obj @ 8 yrs)* R _____ L _____
Wears glasses ◻ Yes ◻ No

◻ **Hearing Screen** *(Obj @ 8 yrs)*
as indicated by risk screen: 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:

◻ **Developmental Surveillance**

Referrals: ◻ Behavioral/Mental Health ◻ Dentist ◻ Vision
◻ Hearing ◻ 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.

School Entry Requirements

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 Trauma[1]

Social/Family: ✓ ***Check those that apply***
◻ Family situation change ◻ No change

_____
Have you lived anywhere but with parent(s)/caretaker(s)?
◻ Yes ◻ No _____
Parent(s)/Caretaker(s) working outside home? ◻ Yes ◻ No
Child care? ◻ Yes ◻ No _____
Sibling(s) in the home? ◻ Yes ◻ No _____
Do you get along with other family members? ◻ Yes ◻ No
If you could, how would you change your life?
home? _____
family?_____

Social Emotional/Stress Indicators: ✓ ***Check those that apply***
Friend(s): ◻ Yes ◻ No
Fun activities: _____
Feelings: ◻ Okay/content
◻ Angry ◻ Less than a week ◻ More than a week
◻ Down/depressed ◻ Less than a week ◻ More than a week
◻ Poor self image ◻ Experienced an emotional loss
Thoughts/plans to harm ◻ Self ◻ Others ◻ Animals ◻ NA
Have you ever had a really scary or bad experience that you cannot forget? ◻ Yes ◻ No _____
Do you have bad dreams or nightmares? ◻ Yes ◻ No

_____

Has anyone ever hit, choked, kicked or hurt you? ◻ Yes ◻ No

_____
Do your friends ever ask you to do things you don't want to do?
◻ Yes ◻ No _____
Has anyone ever touched you where your bathing suit goes or made you touch them when you did not want to? ◻ Yes ◻ No

_____

Risk Indicators: ✓ ***Check those that apply***
◻ Lack of physical activity ◻ Weight or height concerns
Exposure to: ◻ Passive Smoke ◻ Cigarettes ◻ E-Cigs ◻ Chew
◻ Alcohol ◻ Other drugs_____
◻ Access to weapon(s) ◻ Has a weapon(s) ◻ Trouble with the law
Do you wear protective gear, including seat belts? ◻ Yes ◻ No
◻ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
School/Grade_____
◻ Attends school regularly
How are you doing in school?_____
◻ Math at grade level ◻ Reads at grade level
◻ Special classes_____
◻ Trouble at school _____
◻ Participates in extracurricular activities_____

Sex education
◻ Sex education/questions

Physical Health

Current Health Indicators: ✓ ***Check those that apply***
◻ No change
Changes since last visit:

Nutrition: ✓ ***Check those that apply***
◻ Normal eating habits_____
◻ Vitamins:_____
◻ Normal elimination ◻ Normal sleep patterns

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: ◻ Low risk ◻ High risk
Dyslipidemia Risk: ◻ Low risk ◻ High risk
Tuberculosis Risk: ◻ Low risk ◻ High risk

Physical Examination: ✓= ***Normal limits***

◻ General Appearance	◻ Skin	◻ Neurological
◻ Reflexes	◻ Head	◻ Neck
◻ Eyes	◻ Ears	◻ Nose
◻ Oral Cavity/Throat	◻ Lungs	◻ Heart
◻ Pulses	◻ Abdomen	◻ Genitalia
◻ Back	◻ Extremities	
Possible Signs of Abuse	◻ Yes ◻ No	

Health Education/Anticipatory Guidance:
◻ Discussed ◻ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Assessment: ◻ **Well Child** ◻ **Other Diagnosis**

Labs:

Referrals*: *(see above)* ◻ Other
**** See Provider Manual for automatic referrals***

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: ◻ 8 years of age
◻ 9 years of age ◻ Other

[1] Some responses may indicate adverse childhood experiences and may require further evaluation. 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).