

Screen Date \_\_\_\_\_

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

6 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 \_\_\_\_\_

**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 Trauma<sup>1</sup>**

**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 \_\_\_\_\_  
Ability to separate from parent(s)/caretaker(s)?  Yes  No  
Sibling(s) in the home?  Yes  No \_\_\_\_\_  
Do you get along with other family members?  Yes  No

**Social Emotional/Stress Indicators:**  Check those that apply  
Friend(s): \_\_\_\_\_  Yes  No  
Fun activities: \_\_\_\_\_  
Feelings:  Okay/content  Sad  Angry  Down/depressed  
 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

**Developmental**

**Developmental Surveillance:**  Check those that apply  
**Gross Motor:**  Backwards tandem walk  
 Balances on each foot with eyes closed-smooth transition  
**Fine Motor:**  Ties shoes  Draws picture of family  
**Communication:**  Fluent speech  Uses complete sentences  
**Cognitive:**  Knows name and address  
 Knows emergency phone number  Prints name  
 Prints alphabet  
**Social:**  Anger control  Follows rules

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

**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)  
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  
 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:**  Normal eating habits  Vitamins \_\_\_\_\_  
 Normal elimination  Normal sleep patterns

**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?

**Referrals:**  Developmental  Emotional  Dentist  Vision  
 Hearing  Blood lead 10<sub>≥</sub>ug/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 risk  
**Dyslipidemia Risk:**  Low risk  High risk  
**Tuberculosis Risk:**  Low risk  High risk

**Physical Examination:**  = Normal limits

General Appearance  Skin  
 Neurological  Reflexes  
 Head  Neck  
 Eye  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 interaction

**Assessment:**  Well Child  Other Diagnosis

**Labs:**  Blood lead, if needed or high risk

**Referrals:** (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:**  7 years of age  Other

School Entry Requirements



<sup>1</sup> 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).