### Health conditions that may require care at school

- **Immunizations:** Attach current immunization record
  - [ ] UTD  Given, see vaccine record
  - [ ] Vision Acuity Screen (Obj @ 12 yrs) R ______ L ______
  - [ ] Wears glasses  Yes [ ] No
  - [ ] Hearing 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

- **Social Emotional Health/Interpersonal Trauma**
  - [ ] No change
  - [ ] Family situation:  No change
  - [ ] Parent(s)/Caregiver(s) working outside home? Yes [ ] No
  - [ ] Have you lived anywhere but with your parents/caregivers? Yes [ ] No
  - [ ] Sibling(s) in the home? Yes [ ] No
  - [ ] If you get along with other family members? Yes [ ] No
  - [ ] If you could, how would you change your life? Family? ______

- **Traumatic Stress Reactions:** Check one for each question
  - [ ] Feelings over the past 2 weeks:
    - [ ] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Not at all
      - [ ] A little bit (1)  Moderately (2)  Quite a bit (3)  Extremely (4)
    - [ ] Feeling very upset when something reminded you of a stressful experience from the past? Not at all
      - [ ] A little bit (1)  Moderately (2)  Quite a bit (3)  Extremely (4)
  - [ ] Depression Screen:
    - [ ] Check one for each question
      - [ ] If Positive see Periodicity Schedule
        - [ ] Feelings over the past 2 weeks:
          - [ ] Little interest or pleasure in doing things: Not at all
            - [ ] Several days  More than ½ the days
            - [ ] Feeling down, depressed, or hopeless: Not at all
            - [ ] Several days  More than ½ the days

- **Psychosocial/Behavior Screen:** Check those that apply
  - [ ] Fun activities:  Yes [ ] No
  - [ ] Thoughts/plans to harm Self  Others  Animals  NA
  - [ ] Experienced an emotional loss
  - [ ] Risk indicators:
    - [ ] Check those that apply
      - [ ] None identified  Poor self image
      - [ ] Lack of physical activity  Weight or height concerns
      - [ ] Tobacco use: Cigarettes/# per day
      - [ ] E-Cigs  Chew  Passive smoking Risk
      - [ ] Alcohol use: *Other drugs*

- **Screen Date**

- **Provider signature required for validation**
  - [ ] Risk indicators reviewed/screen complete

- **Follow up on previous concerns:**
  - [ ] Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

- **History:**  No change

- **Health Education/Anticipatory Guidance:**
  - [ ] Discussed
  - [ ] Handout(s) given

- **Physical Examination:** Normal limits
  - [ ] General Appearance  Skin  Neurological
  - [ ] Reflexes  Head  Neck
  - [ ] Eyes  Ears  Nose
  - [ ] Oral Cavity/Throat  Lungs  Heart
  - [ ] Pulses  Abdomen  Genitalia
  - [ ] Back  Extremities

- **Referrals**
  - [ ] *See Provider Manual for automatic referrals

- **Assessment:**  Well Child  Other Diagnosis

- **Labs:**
  - [ ] 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:**
  - [ ] 12 years of age  13 years of age
  - [ ] 14 years of age  Other

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2 *See Provider Manual for automatic referrals*