



**ARKANSAS BETTER CHANCE PROGRAM  
2009-2010 WELL CHILD SCREENING (EPSDT) FORM**

To Parent or Guardian:

In order to provide the best learning experience for your child, teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give it to your child's physician or licensed nurse practitioner. Once form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

**Address, City and Zip Code**

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance
<input type="checkbox"/> AR Kids A <input type="checkbox"/> Private Insurance <input type="checkbox"/> AR Kids B <input type="checkbox"/> Other:

**Part I – To be completed by parent or guardian before well child screening.**

Check answers to the following questions. Explain any "yes" answers in the space provided.

- |     |                          |                          |                                                                                                   |
|-----|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------|
|     | Yes                      | No                       |                                                                                                   |
| 1.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health?                                       |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?              |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (like to food, medicine, dust)?                                |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)?                                     |
| 5.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech?                                 |
| 6.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury?                       |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | In the past 12 months, has your child experienced any difficulty with wheezing or night coughing? |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | In the past 12 months, has your child experienced excessive weight loss or weight gain?           |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental examination in the last 12 months?                                    |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the health care provider?       |

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:

I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:

This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

**Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.**

Weight		Height		BMI	Temp	Blood Pressure
lb.	%ile	in.	%ile	%		/

**History Update**

- Yes  No Any changes in patient health since last visit? Explain: \_\_\_\_\_  
 Yes  No Any family history of heart disease for anyone under 55 years of age?  
 Yes  No Any family history of abnormal cholesterol?

**Health**

- Good appetite  Picky or variable eater  
 Drinks lowfat milk  Brushes teeth, sees dentist  
 Encourage diet of fruit and vegetables  
 Limits fast food

**Social and Behavioral**

- Parents discipline appropriately  Praised for good behavior  
 Dresses self, helps at home  Has friends and playmates  
 TV and video games are limited

**Screening and Laboratory Results**

Test	Result	Date	Comments if abnormal
<b>Vision</b> Test type:	L _____ R _____		
<b>Hearing</b> Test type:			
<b>TB</b> Risk: Yes / No			
<b>Hemoglobin</b> Risk: Yes / No			
<b>Cholesterol</b> Risk: Yes / No	mg/dL		

PHYSICAL EXAM		
	Norm	Abnormal
General	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Femoral		
Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>
Extremities		
	<input type="checkbox"/>	<input type="checkbox"/>
Gait	<input type="checkbox"/>	<input type="checkbox"/>
Spine	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>

**Immunizations**

- Yes  No All immunizations are current.  
 Yes  No Child has had all immunizations possible at this time.  
 Child needs:  DTaP  IPV  HepB  HiB  MMR  Varivax  PCV-7 at \_\_\_\_\_ years/\_\_\_\_\_ months

**Referrals**

- Follow up visit needed in \_\_\_\_\_ weeks / months  
 Return check at \_\_\_\_\_ years \_\_\_\_\_ months  
 Needs to see dentist. Referral to be made by physician or nurse practitioner.

**Impressions**

- Well child, normal growth and development  
 \_\_\_\_\_

CLINIC INFORMATION (or stamp)	
Name	_____
Address	_____
City	_____
Zip Code	_____ Phone _____

\_\_\_\_\_, MD / DO / NP  
 Date \_\_\_\_\_