Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

ARKANSAS BETTER CHANCE PROGRAM
2010-2011 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	
☐ AR Kids A	☐ Private Insurance
☐ AR Kids B	☐ 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.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine, dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	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
☐ Drinks lowfat milk
☐ Encourage diet of fruit and vegetables
☐ Limits fast food
☐ Picky or variable eater
☐ Brushes teeth, sees dentist

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

PHYSICAL EXAM

	Norm	Abnormal
General	☐	☐
Head	☐	☐
Neck	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Mouth	☐	☐
Teeth	☐	☐
Lungs	☐	☐
Heart	☐	☐
Femoral Pulses	☐	☐
Genitals	☐	☐
Extremities	☐	☐
Gait	☐	☐
Spine	☐	☐
Skin	☐	☐
Neuro	☐	☐

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L_____ R_____		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

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
☐ _____

_____, MD / DO / NP
Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____ Phone_____