



**ARKANSAS BETTER CHANCE PROGRAM
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
Vision Test type:	L _____ R _____		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol 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 _____