Preston County Pre-K
Dental Exam

Child's Name_____ Date Exam Completed _____

Birthdate _____

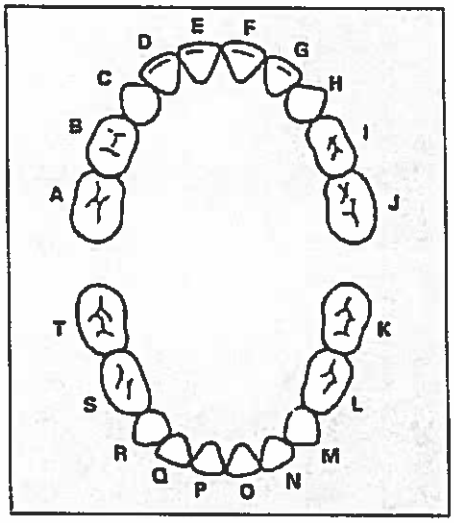
ORAL CONDITION

UPPER

Key

X Missing
Decayed
Filled

LEFT



RIGHT

LOWER

****

Number of times per day child brushed teeth _____

Gum Condition:

____Normal ____ Swollen ____ Bleeds Easily ____ Infected

Dental Needs:

____ None ____ Treatment ____ Cleaning ____ Fluoride Supplement ____ Oral Hygiene Instruction

____ Other: _____

Follow-up Needed: No Yes Reason _____

Signature: _____ Stamp:

Printed_____

Address: _____

Phone _____

Return to: Preston County Pre-K (Fax) 304-329-0720 (Phone) 304-329-0580 x220

WEST VIRGINIA Department of Health & Human Resources

Application for Certified Copy of West Virginia Birth Certificate

Please complete on-line, print, sign, and mail as instructed below or print except where signature is required.

The following pertains to information that would be found on the certificate being requested.

Name of person on the certificate

First Middle Last

Date of Birth

Month/Day/Year

Mother's Maiden Name

First Middle Last

Sex:

☐ Male ☐ Female

Father's Name

First Middle Last

Place of Birth

City County State

Hospital

Requestor's Relationship:

Parent/Grandparent ☐ Guardian or agent ☐ Child/Grandchild ☐

Certificate of my own birth ☐ Spouse ☐ Brother/Sister ☐

Making false statements and misuse of vital records will result in criminal and civil penalties pursuant to WV Code §16-5-38.

Signature (Required)

Printed Name (Required)

Requesting _____ copies at $12.00 per copy and enclosing $_____.

Please send check or money order. Please do not send cash.
Make checks payable to: Vital Registration

Send copies to: Print your address below.

( ) Area Code

Your daytime telephone number

City State Zip

E-Mail address

Submit form with check or money order to:

Vital Registration
Room 165
350 Capitol Street
Charleston, WV 25301-3701

Telephone: (304) 558-2931

Last Revised 1/9/09

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

5 Year Form

Name_____DOB_____Age_____Sex: M F Wt_____Ht_____BP_____Temp_____Pulse_____Screen Date_____

Allergies: ◻ NKDA _____ Current Meds: ◻ None _____

Accompanied by: ◻ Parent ◻ Grandparent ◻ Foster parent/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 dental problems:

◻ Developmental Surveillance: ✓ *Check those that apply*
Gross Motor:
◻ Walks, climbs, runs ◻ May be able to skip
◻ Up/down stairs alternating feet, without support
Fine Motor:
◻ Copies ▲or ■ ◻ Prints some letters
◻ Draws figure w/head, arms and legs ◻ Dresses self
◻ Has manual dexterity
Communication:
◻ Able to recall parts of story ◻ Fluent speech
◻ Uses complete sentences ◻ Speaks in short sentences
◻ Uses future tense ◻ Second language spoken at home
Cognitive:
◻ Knows address and phone # ◻ Can count on fingers
◻ Follows 2-3 step instructions
◻ Recognizes many letters of the alphabet
Social:
◻ Listens to stories ◻ Follows rules
◻ Plays interactive games with peers
◻ Elaborate fantasy play/make believe/dress up

Immunizations: Attach current immunization record
◻ UTD ◻ Given, see vaccine record
Referrals: ◻ Developmental ◻ Dentist ◻ Vision
◻ Hearing ◻ Blood lead 10≥ug/dl ◻ CSHCN 1-800-642-9704
◻ Other:

Provider signature required for validation
◻ Risk indicators reviewed/screen complete

_____
Please Print Name of Facility or Clinic

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements.

History: ◻ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses or visits to other providers:

Social/Family History: ✓ *Check those that apply*
◻ No change ◻ Family situation change

Parents working outside home? ◻ Mother ◻ Father
Child care? ◻ No ◻ Yes _____
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
◻ No change
Changes since last visit:

School: Grade_____◻ Attends school regularly ◻ N/A
◻ Ability to separate from parents _____
Likes most about school_____
Likes least about school_____
◻ Gets along with other family members

◻ GROWTH PLOTTED ON GROWTH CHART
◻ BMI CALCULATED AND PLOTTED ON BMI CHART
◻ Normal elimination
◻ Normal sleep patterns
◻ Appropriate behavior

Nutrition: ◻ Normal eating habits
◻ Vitamins_____
◻ Passive smoking risk ◻ Yes ◻ No

✓ *Check those that apply*
Tuberculosis Risk: ◻ Low risk ◻ High risk
◻ Increased risk of exposure d/t Contacts/Travel/Immigration
◻ Radiographic or clinical findings suggestive of TB

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?

Physical Examination: ✓ *Check those that apply*

◻ General Appearance		◻ Skin
◻ Neurological		◻ Reflexes
◻ Head		◻ Neck
◻ Eyes	◻ Red Reflex	◻ Ocular Alignment
◻ Nose	◻ Ears	◻ Oral Cavity/Throat
◻ Lungs	◻ Heart	◻ Pulses
◻ Abdomen		◻ Genitalia
◻ Back		◻ Extremities

Abnormal Findings and Comments:
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
Other:

Assessment: ◻ Well Child ◻ Other diagnosis

Plan/Referrals:
For treatment plans requiring authorization, please complete the Medical Necessity Form on the reverse.

Labs: ◻ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
◻ Other referral(s)

Follow Up/Next Visit: ◻ 6 years of age ◻ Other