



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 MO HEALTHNET DIVISION  
**HEALTHY CHILDREN AND YOUTH SCREENING GUIDE**  
**4 YEARS**

DATE		NAME		DATE OF BIRTH	
MO HEALTHNET NUMBER			MEDICAL RECORD NUMBER		
TEMP	RR	HEIGHT	%	BMI	ALLERGIES <input type="checkbox"/> NKDA
PULSE	HEAD CIRC	WEIGHT	%		MEDICATIONS <input type="checkbox"/> NONE
<b>I. INTERVAL HISTORY/PARENT'S CONCERNS:</b>					COMMENTS
Chronic Illnesses: _____		<input type="checkbox"/> ER/Hospital utilization since last visit			
<input type="checkbox"/> Triggers reviewed: _____					
<input type="checkbox"/> Medications changed/refilled: _____					
<input type="checkbox"/> Education		<input type="checkbox"/> Consult/Referral			
Sleep:*					
Activity: _____					
Child Care: _____					
Peer Involvement:*					
Family High Risk Factors:* _____					
Nutrition: <input type="checkbox"/> <b>WIC Referral</b>					
<input type="checkbox"/> Encourage all food groups: _____					
Output: Urine: _____ Stools: _____					
<b>II. UNCLOTHED PHYSICAL EXAM:</b> <input type="checkbox"/> <b>Check Growth Chart</b>					
SYSTEM	NL	ABN	NE	COMMENTS	
General					
Skin					
Head					
Eyes					
Ears					
Nose					
Oropharynx					
Neck					
Lungs					
Heart					
Pulses					
Abdomen					
Back					
GU					
Skeletal					
Neuro					
SIGNATURE				DATE	

FULL SCREEN (I-X)	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	HEARING SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>
PARTIAL SCREEN (I-V)	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	VISION SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>
DEVELOPMENTAL & MH SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	DENTAL SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>

**III. ANTICIPATORY GUIDANCE** (Check all that apply)

<input type="checkbox"/> Sleeping problems*	<input type="checkbox"/> Traffic hazards	<input type="checkbox"/> Pre-kindergarten	COMMENTS
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Water safety/pools	<input type="checkbox"/> Sun Exposure	
<input type="checkbox"/> Cursing	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Parental smoking	
<input type="checkbox"/> Stuttering	<input type="checkbox"/> Fire safety	<input type="checkbox"/> Smoke detector	
<input type="checkbox"/> Discipline/Time out*	<input type="checkbox"/> Matches, lighter safety	Feeding:	
<input type="checkbox"/> Hyperactivity*	<input type="checkbox"/> Bicycle helmet	<input type="checkbox"/> 3 meals with snacks	
<input type="checkbox"/> Television/Exercise	<input type="checkbox"/> Car seat/Airbags	<input type="checkbox"/> Variety of food	
<input type="checkbox"/> Reading to child	<input type="checkbox"/> Ingestions/poisons	<input type="checkbox"/> Proper amounts	

**IV: LAB/IMMUNIZATIONS:** Labs:  Blood lead level (if not done previously at 24 months)  Other \_\_\_\_\_

Immunizations given today: \_\_\_\_\_

UTD  Written information given  Consent signed (Follow the recommended immunization schedule approved by the ACIP, AAP, and AAFP)

**V. LEAD SCREEN**  Lead Assessment Guide complete  Negative screen  Positive screen - draw blood lead level

**VI. DEVELOPMENTAL AND MENTAL HEALTH:**  Parents As Teachers referral (Check all that apply)

<b>Minimal Skills</b> <input type="checkbox"/> Count one block <input type="checkbox"/> Name friend <input type="checkbox"/> Put on T-shirt - R <input type="checkbox"/> Name one color <input type="checkbox"/> Use of two objects <input type="checkbox"/> Attentive ≥ 10 min. <input type="checkbox"/> Wash and dry hands - R <input type="checkbox"/> Appropriate emotional expression	<b>Emerging Skills</b> <input type="checkbox"/> Name, age, sex <input type="checkbox"/> Awareness of gender <input type="checkbox"/> Pronouns/plurals <input type="checkbox"/> Brush teeth without help <input type="checkbox"/> Discuss activities <input type="checkbox"/> ≥ 4 colors <input type="checkbox"/> 3 adjectives <input type="checkbox"/> Past tense	COMMENTS
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**VII. FINE MOTOR/GROSS MOTOR:** (Check all that apply)

<b>Minimal Skills</b> <input type="checkbox"/> Thumb wiggle <input type="checkbox"/> Stacks 8 cubes <input type="checkbox"/> Imitates vertical line <input type="checkbox"/> Broad jump <input type="checkbox"/> Balances on each foot for 2 seconds	<b>Emerging Skills</b> <input type="checkbox"/> Rides tricycle <input type="checkbox"/> Jumps in place <input type="checkbox"/> Dress without help <input type="checkbox"/> Stacks 10 blocks <input type="checkbox"/> Copies circle/cross <input type="checkbox"/> Picks longer line <input type="checkbox"/> Draw person - 3 parts <input type="checkbox"/> Balances on 1 foot for 3-5 seconds	COMMENTS
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<b>VIII. HEARING:</b> (Check all that apply) <input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Ear exam with pneumatic otoscope <input type="checkbox"/> Observational screening with noisemaker <input type="checkbox"/> ERA/ABR screen for infant in tertiary care > 5 days <input type="checkbox"/> Family history of hearing disorders PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> ear infection/ <input type="checkbox"/> head injury/ <input type="checkbox"/> congenital anomalies/ <input type="checkbox"/> meningitis/ <input type="checkbox"/> mumps/ <input type="checkbox"/> cerebral palsy <input type="checkbox"/> Tympanometry <input type="checkbox"/> Identifies familiar pictures <input type="checkbox"/> Names desired objects (candy, juice)	<b>IX. VISION:</b> (Check all that apply) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> ocular movements <input type="checkbox"/> pupillary response <input type="checkbox"/> tracking <input type="checkbox"/> Objective testing including Snellen E, distance acuity, and light reflex/cover test <input type="checkbox"/> Exam of external eye, funduscopic exam <input type="checkbox"/> Family history of visual disorders <input type="checkbox"/> Eye injuries, foreign substances PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration
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COMMENTS

<b>X. DENTAL</b> <input type="checkbox"/> Teeth brushing by parents <input type="checkbox"/> Normal tooth eruption times <input type="checkbox"/> Referral for routine preventative dental care every 6 months <input type="checkbox"/> Assess teeth development and oral hygiene - Teeth cleaning <input type="checkbox"/> Fluoride supplements if water fluoridation less than 0.7 ppm	NOTE: It is recommended that assessment preventive dental services and oral treatments for children begin at age 6-12 months and be repeated every 6 months or as medically indicated.
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ASSESSMENT/EDUCATION/PLAN

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ORDERS

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_