



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
8-9 YEARS

DATE		NAME		DATE OF BIRTH	
MO HEALTHNET NUMBER				MEDICAL RECORD NUMBER	
TEMP	RR	HEIGHT		BMI	ALLERGIES
			%		<input type="checkbox"/> NKDA
PULSE	BP	WEIGHT			MEDICATIONS
			%		<input type="checkbox"/> NONE
I. INTERVAL HISTORY/PARENT'S CONCERNS/CHILD'S CONCERNS:					COMMENTS

Menstrual Hx: Menarche age _____ years LMP: _____					
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					
Fatigue/Sleep:* _____					
School:* _____					
Peers:* _____					
Accidents:* _____					
Family High Risk Factors:* _____					
Nutrition: <input type="checkbox"/> Encourage all food groups: _____					
Output: Urine: _____ Stools: _____					
II. UNCLOTHED PHYSICAL EXAM: <input type="checkbox"/> Check Growth Chart					
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 AND MENTAL HEALTH 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"/> Values	<input type="checkbox"/> Pedestrian safety	<input type="checkbox"/> Chores	COMMENTS
<input type="checkbox"/> Peer relations*	<input type="checkbox"/> Swimming/diving	<input type="checkbox"/> Money responsibility	
<input type="checkbox"/> Need for privacy	<input type="checkbox"/> Firearms/homicide	<input type="checkbox"/> Puberty	
<input type="checkbox"/> School performance*	<input type="checkbox"/> Fire safety	<input type="checkbox"/> Television	
<input type="checkbox"/> Sexual education	<input type="checkbox"/> Bicycle safety/helmet	Feeding:	
<input type="checkbox"/> Discipline*	<input type="checkbox"/> Seatbelts/Airbags	<input type="checkbox"/> 3 meals with snacks	
<input type="checkbox"/> Exercise/Physical activity	<input type="checkbox"/> Tool safety	<input type="checkbox"/> Variety of food	
<input type="checkbox"/> Supervision	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Proper amounts	
<input type="checkbox"/> Parental smoking	<input type="checkbox"/> Medicines	<input type="checkbox"/> Obesity	

IV. LAB/IMMUNIZATIONS: Labs: Hct (if high risk) UA (if high risk) Cholesterol/Lipid profile (if high risk) 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 N/A for this age.

VI. DEVELOPMENTAL AND MENTAL HEALTH: (Check all that apply)

<input type="checkbox"/> School performance	<input type="checkbox"/> Follows rules at school	COMMENTS
<input type="checkbox"/> Sexual development	<input type="checkbox"/> Follows rules at home	
<input type="checkbox"/> Attends school easily	<input type="checkbox"/> Attentive ≥ 60 min.	
<input type="checkbox"/> Appropriate emotional expression		

VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

<input type="checkbox"/> Handwriting	COMMENTS
<input type="checkbox"/> Sports	

<p>VIII. HEARING: This screening should be performed annually.</p> <input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Child's perception of hearing <input type="checkbox"/> Ear exam with pneumatic otoscope <input type="checkbox"/> Family history of hearing disorders PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> recurrent ear infections/ <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 upon indication <input type="checkbox"/> Pure tone audiometry (sweep screen) upon indication	<p>IX. VISION: This screening should be performed annually.</p> <input type="checkbox"/> Parental/child's perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> pupillary response <input type="checkbox"/> tracking <input type="checkbox"/> ocular movement <input type="checkbox"/> Objective testing including Snellen E, distance acuity, light reflex/cover test, and color discrimination <input type="checkbox"/> Exam of external eye, funduscopic exam <input type="checkbox"/> School performance <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	COMMENTS
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<p>X. DENTAL <input type="checkbox"/> Referral for routine preventative dental care q 6 months</p> <input type="checkbox"/> Teeth brushing/flossing <input type="checkbox"/> Normal tooth eruption times <input type="checkbox"/> Assess teeth development and oral hygiene - Teeth cleaning <input type="checkbox"/> Fluoride supplements if water fluoridation less than 0.7 ppm	<p>NOTE: It is recommended that assessment preventative dental services and oral treatments for children begin at age 6-12 months and be repeated every 6 months or as medically indicated.</p>
	COMMENTS

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE	DATE
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