Little Rock School District Pre-Kindergarten Health/Well-Child Screening (EPSDT) Form

Parents and Guardians:

Little Rock School District provides free Pre-Kindergarten to eligible three- and four-year old children in conjunction with DHS and Arkansas Better Chance (ABC). State regulations require that any child enrolled in the ABC Pre-K program have a well-child screening conducted by a medical professional and have proof of current immunizations. Complete this form and take this with you to your child's well-child exam. You will need to provide this document to the school when you check in for Pre-K.

Part I: Child/Family Information				
Child's Name (First, Middle, Last)	Child's Date of Birth	Gender	Child's Birth Weight	Age of Mother at Child's Birth
		☐ Male ☐ Female	____ lbs ____ oz.	
Parent/Guardian Name	Address			
Type of Insurance	☐ AR Kids A	☐ AR Kids B	☐ Private Insurance	☐ Other

Part II: Child Health Information (Completed by Parent Prior to Well-Child Screening)		
✓Check Yes or No to each of the following Questions; If Yes, please explain in the space provided.		
1. Do you have any concerns about your child's general health?	☐ Yes ☐ No	If yes, explain:
2. Has your child been diagnosed with any chronic illnesses or diseases (i.e. asthma, diabetes)?	☐ Yes ☐ No	If yes, explain:
3. Does your child have any allergies (food, medication, dust/mold, etc.)?	☐ Yes ☐ No	If yes, explain:
4. Does your child take any medication(s) (daily or occasionally?	☐ Yes ☐ No	If yes, list medications:
5. Does your child have any hearing, vision, or speech issues or problems?	☐ Yes ☐ No	If yes, explain:
6. Has your child been hospitalized, had an operation or major illness or injury?	☐ Yes ☐ No	If yes, explain:
7. In the past 12 months, has your child experiences any difficulty with wheezing or night coughing?	☐ Yes ☐ No	If yes, describe:
8. In the past 12 months, has your child experienced excessive weight loss or gain?	☐ Yes ☐ No	If yes, explain:
9. Has your child had a dental exam in the last 12 months?	☐ Yes ☐ No	If yes, when:
10. What other health concerns would you like to discuss with the medical professional?	Describe:	

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 LRSD Pre-K program operated under DHS/ABC.

_____ _____

Parent/Guardian Signature Date

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Child's Name (First, Middle, Last)	Child's Date of Birth	Gender	Parent/Guardian Name
		☐ Male ☐ Female	

HEALTH CARE PROFESSIONAL:

This child has applied for the LRSD Pre-K Program operated under DHS/Arkansas Better chance. State regulations require a comprehensive well-child screening for all participating children. The Division of Child Care and Early Childhood Education recommends and Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age appropriate. For children 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	
	Ages 1-4 Years	Ages 5-11 Years	Ages 1-4 Years	Ages 5-11 Years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part III: Health Profile (Completed by Health Care Professional)									
Weight		Height		BMI	Temperature	Blood Pressure			
lbs.	%tile	in.	%tile	%		/			

History/Update

Any changes in child's health since last visit? ☐ Yes ☐ No Explain:

Any family history of heart disease for anyone under 55 years of age? ☐ Yes ☐ No

Any family history of abnormal cholesterol? ☐ Yes ☐ No

HEALTH

- ☐ Good appetite
- ☐ Drinks lowfat milk
- ☐ Encourages 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

	NORMAL	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(s)	Date	Comment(s) if abnormal
Vision Test Type:	R: L:		
Hearing Test Type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

IMMUNIZATIONS

☐ Yes ☐ No All Immunications are current.

☐ Yes ☐ No Child has had all immunizations possible.

Child needs: ☐ DTaP ☐ IPV ☐ HepB ☐ HIB ☐ MMR ☐ Varivx

☐ PCV-7 at ___ years/ ____ months

REFERRALS

☐ Follow up visit needed in ___ weeks / months

☐ Return check in ____ years ____ months

☐ Needs to see dentist. Referral to be made.

IMPRESSIONS

☐ Well child, normal growth and development ☐ _____

HEALTH CARE PROFESSIONAL

_____, MD / DO / NP Date: _____

CLINIC INFORMATION (or Stamp)

Name:

Address:

City/State/Zip:

Phone: