



**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	
D AR Kids A      D Private Insurance D AR Kids B      D 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.  | D   | D  | Do you have any concerns about your child's general health?                                       |
| 2.  | D   | D  | Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?              |
| 3.  | D   | D  | Does your child have any allergies (like to food, medicine, dust)?                                |
| 4.  | D   | D  | Does your child take any medications (daily or occasionally)?                                     |
| 5.  | D   | D  | Does your child have any problems with vision, hearing or speech?                                 |
| 6.  | D   | D  | Has your child had any hospitalization, operation, major illness or injury?                       |
| 7.  | D   | D  | In the past 12 months, has your child experienced any difficulty with wheezing or night coughing? |
| 8.  | D   | D  | In the past 12 months, has your child experienced excessive weight loss or weight gain?           |
| 9.  | D   | D  | Has your child had a dental examination in the last 12 months?                                    |
| 10. | D   | D  | 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**

D Yes D No Any changes in patient health since last visit? Explain: \_\_\_\_\_  
D Yes D No Any family history of heart disease for anyone under 55 years of age?  
D Yes D No Any family history of abnormal cholesterol?

**Health**

D Good appetite D Picky or variable eater  
D Drinks lowfat milk D Brushes teeth, sees dentist  
D Encourage diet of fruit and vegetables  
D Limits fast food

**Social and Behavioral**

D Parents discipline appropriately D Praised for good behavior  
D Dresses self, helps at home D Has friends and playmates  
D TV and video games are limited

**Screening and Laboratory Results**

Test	Result	Date	Comments if abnormal
<b>Vision</b>	L _____ R _____		
<b>Hearing</b>			
<b>TB</b>			
Risk: Yes / No			
<b>Hemoglobin</b>			
Risk: Yes / No			
<b>Cholesterol</b>			
Risk: Yes / No	mg/dL		

**PHYSICAL EXAM**

	Norm	Abnormal
General	D	D
Head	D	D
Neck	D	D
Eyes	D	D
Ears	D	D
Nose	D	D
Throat	D	D
Mouth	D	D
Teeth	D	D
Lungs	D	D
Heart	D	D
Femoral		
Pulses	D	D
Genitals	D	D
Extremities		
Gait	D	D
Spine	D	D
Skin	D	D
Neuro	D	D

**Immunizations**

D Yes D No All immunizations are current.  
D Yes D No Child has had all immunizations possible at this time.  
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at \_\_\_\_\_ years / \_\_\_\_\_ months

**Referrals**

D Follow up visit needed in \_\_\_\_\_ weeks / months  
D Return check at \_\_\_\_\_ years \_\_\_\_\_ months  
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

**Impressions**

D Well child, normal growth and development  
D \_\_\_\_\_

\_\_\_\_\_, MD / DO / NP  
Date \_\_\_\_\_

**CLINIC INFORMATION (or stamp)**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Zip Code \_\_\_\_\_ Phone \_\_\_\_\_