



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 MO HEALTHNET DIVISION  
**HEALTHY CHILDREN AND YOUTH SCREENING GUIDE**  
**10-11 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
<b>I. INTERVAL HISTORY/PARENT'S CONCERNS/CHILD'S CONCERNS:</b>					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:* _____					
Family High Risk Factors:* _____					
High Risk Behaviors:* <input type="checkbox"/> None <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs					
<input type="checkbox"/> Weapons <input type="checkbox"/> Sexual activity <input type="checkbox"/> Accidents <input type="checkbox"/> Other _____					
Nutrition: <input type="checkbox"/> Encourage all food groups: _____					
Output: Urine: _____ Stools: _____					
<b>II. UNCLOTHED PHYSICAL EXAM: <input type="checkbox"/> 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 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"/> Peer relations* <input type="checkbox"/> Hobbies <input type="checkbox"/> Need for privacy <input type="checkbox"/> School performance* <input type="checkbox"/> Body image* <input type="checkbox"/> Discipline* <input type="checkbox"/> Exercise/Physical activity <input type="checkbox"/> Sex education <input type="checkbox"/> Television	<input type="checkbox"/> Firearms/Homicide* <input type="checkbox"/> Suicide* <input type="checkbox"/> Vehicular accidents <input type="checkbox"/> Sports injuries <input type="checkbox"/> Bicycle safety/helmet <input type="checkbox"/> Seatbelts/Airbags <input type="checkbox"/> Pool/Water safety <input type="checkbox"/> Chores <input type="checkbox"/> Contraception/Family planning	<input type="checkbox"/> Alcohol* <input type="checkbox"/> Drugs* <input type="checkbox"/> Smoking Feeding: <input type="checkbox"/> 3 balanced meals <input type="checkbox"/> Fat content <input type="checkbox"/> Iron <input type="checkbox"/> Calcium <input type="checkbox"/> Obesity	COMMENTS
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**IV. LAB/IMMUNIZATIONS:** Labs: If high risk:  Hct  UA  Lipid profile If sexually active:  PAP  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/accepts discipline <input type="checkbox"/> Follows rules at home/accepts discipline	<input type="checkbox"/> Stable mood <input type="checkbox"/> Stable behavior <input type="checkbox"/> Engages in age appropriate social activities	<input type="checkbox"/> Stable sleep/appetite	COMMENTS
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**VII. FINE MOTOR/GROSS MOTOR:** (Check all that apply)

<input type="checkbox"/> Handwriting <input type="checkbox"/> Sports	COMMENTS
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<p><b>VIII. HEARING:</b> 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><b>IX. VISION:</b> 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"/> tracking <input type="checkbox"/> pupillary response <input type="checkbox"/> ocular movement <input type="checkbox"/> Objective testing including Snellen E, acuity (near and far), 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><b>X. DENTAL</b> <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>
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ASSESSMENT/EDUCATION/PLAN

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ORDERS

SIGNATURE	DATE
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