

New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

CHILDHOOD: 5 YEARS

DATE: _____

Child's Name: _____			Date of Birth: _____		
Allergies: _____			Current Medications: _____		
Illnesses/Accidents/Problems/Concerns since birth: _____					

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	My child eats a variety of foods	<input type="checkbox"/>	<input type="checkbox"/>	My child can balance on one foot
<input type="checkbox"/>	<input type="checkbox"/>	My child can play make believe	<input type="checkbox"/>	<input type="checkbox"/>	My child recognizes most letters and can print some
<input type="checkbox"/>	<input type="checkbox"/>	My child shows an ability to understand the feelings of others			

WEIGHT KG/LB PERCENTILE: _____	HEIGHT CM/FT/INS PERCENTILE: _____	BLOOD PRESSURE: _____	Diet: _____
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☐ Review of Systems ☐ Review of Family History

Screening	N	A	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Development	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Communication	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physical	N	A		N	A	
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>				

Describe findings:

☐ Vitamin Supplement ☐ WIC Referral

☐ Fluoride Supplement ☐ Dental Referral

☐ Review Immunization Record ☐ Hgb/Hct

☐ TB Test (if high risk factors present) ☐ Urinalysis

☐ Cholesterol Screening (for high risk children)

☐ Lead Risk Assessment (verbal)

Elimination: _____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Development Benchmarks	<input type="checkbox"/> Adequate Sleep/Habits
<input type="checkbox"/> Regular Physical Activities	<input type="checkbox"/> Discipline/Limits
<input type="checkbox"/> Car/Booster Seat Safety	<input type="checkbox"/> School Readiness
<input type="checkbox"/> Safety (general)	<input type="checkbox"/> Limit TV
<input type="checkbox"/> Lead Poison Prevention	<input type="checkbox"/> Helmets
<input type="checkbox"/> Passive Smoke	

Other: _____

Assessment:

Diagnosis:

Treatment Plan:

REFERRALS:

IMMUNIZATIONS: ☐ given (see VFC Form) ☐ up to date

NEXT VISIT: 6 YEARS OF AGE

Health Provider Signature: _____