

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

## CHILDHOOD: 8 YEARS

DATE: \_\_\_\_\_

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

  

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	My child eats breakfast every day	<input type="checkbox"/>	<input type="checkbox"/>	My child seems rested when he/she awakens
<input type="checkbox"/>	<input type="checkbox"/>	My child is doing well in school	<input type="checkbox"/>	<input type="checkbox"/>	My child handles stress, anger, and frustration appropriately
<input type="checkbox"/>	<input type="checkbox"/>	My child has one or more close friends	<input type="checkbox"/>	<input type="checkbox"/>	My child gets some physical activity every day

  

WEIGHT KG/LB PERCENTILE: _____	HEIGHT CM/FT/INS PERCENTILE: _____	BLOOD PRESSURE: _____	Diet: _____
-----------------------------------	---------------------------------------	-----------------------	-------------

  

☐ 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"/>	_____

  

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:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ Dental Referral

☐ Fluoride Supplement

☐ Vitamin Supplement

☐ TB Test (if high risk factors present)

☐ Cholesterol Screening (for high risk children)

☐ Review Immunization Record

  

Elimination: \_\_\_\_\_

Sleep: \_\_\_\_\_

Other: \_\_\_\_\_

**Health Education/Anticipatory Guidance:**  
(CHECK ALL COMPLETED)

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Development	<input type="checkbox"/> Parenting Issues
<input type="checkbox"/> Regular Physical Activities	<input type="checkbox"/> Child Care Issues
<input type="checkbox"/> Seat Belt	<input type="checkbox"/> Adequate Sleep
<input type="checkbox"/> Safety (general)	<input type="checkbox"/> Helmets
<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> School Issues
<input type="checkbox"/> Limit TV	

Other: \_\_\_\_\_

**Assessment:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

**Treatment Plan:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REFERRALS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**NEXT VISIT: 9 YEARS OF AGE**

Health Provider Signature: \_\_\_\_\_