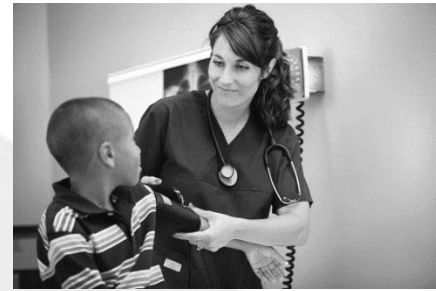


For more than 20 years Well Child, with its school partnerships, has helped parents identify many hidden health issues that need medical attention. Well Child offers yearly checkups, yearly eye exams and treatment of most minor illnesses and injuries at no cost to the school or district. Well Child exams are the same as an annual visit to a primary provider or optometrist. You will be made aware of all findings and given information about any recommendation for your child to have further health evaluations.

### Well Child Yearly Checkup

- Vision and hearing screenings
- A complete head-to-toe physical exam (clothes lifted)
- Immunization review
- Lab (blood work)-finger stick
- A complete history including developmental/behavioral screenings



### Well Vision Yearly Eye Exam



- Licensed optometrist conducts all examinations
- Optometrist will determine any vision and eye health problems
- If clinically needed, your child's eyes may be dilated with parental permission
- Glasses will be prescribed and provided when necessary

Well Child will bill your insurance carrier or managed care organization for the exam(s) and/or treatment. For any questions regarding coverage or benefits, please contact your insurance carrier.

#### For annual checkups Well Child can be paid by the following:

##### Tenn Care Insurance Plans

- Amerigroup
- BlueCare
- CoverKids
- TennCare Select
- United Health Care Community Plan

##### Commercial Insurance Plans

- Aetna
- BlueCross (Network P Only)
- Cigna
- Humana
- Tricare
- United Health Care
- UMR
- Other plans

#### For annual vision exams, Well Child can be paid by the following insurance carriers:

- BlueCare
- CoverKids
- TennCare Select
- United Health Care Community Plan (March Vision)

Contact us at 1-901-728-5858 or 866-403-5858 if you have any questions or would like to be present for the exam(s). For information about Well Child's Privacy Practices, please visit [www.wellchild.com](http://www.wellchild.com).



# Well Child™

## TREATMENT

With your permission, Well Child can treat many minor illnesses and injuries identified during the physical exam.

### Minor Illnesses

Well Child can treat the following minor illnesses:

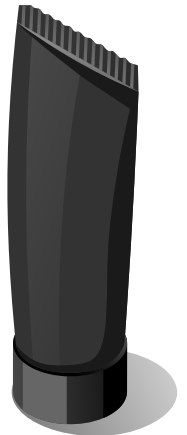
- Bladder/Urinary Infection
- Cold
- Constipation
- Cough
- Diarrhea
- Ear Infections
- Flu
- Headaches
- Heartburn
- Nausea
- Pinkeye
- Seasonal Allergies
- Sore Throat
- Sties
- Toothache



### Skin Conditions

Well Child can treat the following skin conditions:

- Acne
- Athlete's Foot
- Cold Sores
- Hand, Foot and Mouth Disease
- Impetigo
- Insect Bites
- Lice
- Poison Ivy/Oak
- Ringworm
- Sunburn



### Minor Injuries

Well Child can treat the following minor injuries:

- Bursitis
- Muscle Sprains/Strains
- Muscle/Joint Pain



### Wellness

Well Child can provide the following services to address weight-related health issues:

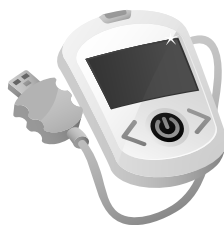
- Individual and Group Counseling
- Nutrition Education and Counseling



### Screenings and Monitoring

Well Child may use the following screenings or tests to accurately diagnose health issues in students:

- Strep Testing
- Basic Urinalysis
- Glucose Screening
- Hematocrit
- Mononucleosis Testing



### Medication

When a prescription is needed, Well Child will send an electronic prescription to the pharmacy of your choice.

*\*No narcotic medications will be prescribed.*



### Ready to sign up?

Complete the attached Well Child consent form, call (866) 403-5858 to sign up over the phone, or sign up online at [www.wellchild.com](http://www.wellchild.com) (scan QR code).





\* 2 4 E N C R I S C S \*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Phone: \_\_\_\_\_

## PARENT/LEGAL GUARDIAN INFORMED CONSENT

By completing the information requested below and signing this form I authorize Well Child to send screening results home with my child in a sealed envelope, to release information to my insurance carrier in order to process payment claims, and to receive payment of medical benefits for services rendered. For purposes of treatment and referral, I authorize release of medical information to the Health Department, the school system, and my child's physician/primary care provider, and/or optometrist. I give permission to the school district to release my child's immunization (shot) record for review by Well Child. This consent is valid for the greater of the school system academic calendar or one year from the date this packet is returned to Well Child, unless earlier revoked in writing. Under the Affordable Care Act, Medicaid and most commercial health plans cover an annual Preventive Health Exam at no cost to the patient. If my child has received a preventative exam within the past year, I request and authorize Well Child to perform another after obtaining my verified verbal consent. I agree to pay Well Child any copayment or coinsurance for treatment, as required by my child's health insurer. If uninsured, I agree to pay Well Child for services provided.

I have reviewed Well Child's **Notice of Privacy Practices** available at [www.wellchild.com](http://www.wellchild.com) and I may obtain a written copy in the mail by calling Well Child at 1-866-403-5858 toll free or checking the box below. I have been notified of access of Well Child's privacy practices.  I wish to receive a copy of Well Child's Notice of Privacy Practices in the mail.

### CHECKUP



**PLEASE SIGN AND DATE** below to give permission for your child to receive a check up in school or via telehealth.

SIGN HERE

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### EYE EXAM



**PLEASE SIGN AND DATE** below to give permission for your child to receive a eye exam.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SIGN HERE

Pupil dilation is using eye drops to make the pupil larger to help the doctors examine the inner health. Dilation can include some sensitivity to light and mild blurred vision for about 2 – 3 hours.

 I authorize pupil dilation I will schedule pupil dilation at a later date

### FLUORIDE 3, 4, or 5 -years-olds ONLY



Fluoride strengthens your child's teeth and decreases tooth decay. Please check one below:

 I authorize fluoride treatment I will schedule fluoride treatment at a later date

### TREATMENT

**PLEASE SIGN AND DATE** below to give permission for your child to be treated minor illnesses or conditions identified during check up in school or telehealth.



Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SIGN HERE

Preferred Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

It is very important that you complete every question.

Name of Student's School \_\_\_\_\_ Grade \_\_\_\_ Section \_\_\_\_ Teacher \_\_\_\_\_

### STUDENT'S INFORMATION

LAST NAME	FIRST	M.I.	SEX: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	AGE
ADDRESS			RACE: <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER	
CITY	STATE	ZIP	ETHNICITY: <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC	
Main language at home:			Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
Student's doctor or clinic:			Phone Number:	
<b>Well Child will bill your insurance carrier or managed care organization for the exam (s).</b> Circle name of TennCare provider: United Health Care Community Plan, TennCare Select, BlueCare, Amerigroup, Other _____				
Student's Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		TennCare Member ID Number		Tricare ID (9 or 11 digits)
Insurance Company: _____			Policy #: _____	
Policy holder name: _____			Date of Birth: _____	
<b>*Vision Exams only accept the following insurance carrier: United Health Care (MarchVision), TennCare Select, BlueCare and CoverKids</b>				

### PARENT/LEGAL GUARDIAN'S INFORMATION

RESPONSIBLE PARTY'S NAME:		RELATIONSHIP TO STUDENT:
HOME PHONE NUMBER: ( )	WORK PHONE NUMBER: ( )	CELL PHONE NUMBER: ( )
Check preferred method of contact: <input type="radio"/> Phone <input type="radio"/> Text <input type="radio"/> Email		
Email Address:		
<input type="radio"/> By checking here you consent to receive notifications by text message.		

Friend or relative whom we can contact in case of emergency and share medical information.		
Name:	Relationship:	Phone: ( )

# MEDICAL HISTORY



Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Answer Yes with a

**1. Child's Health History:** Has your child had any of the following?

UNKNOWN  NO TO ALL

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Acne/Skin problems | <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Navel Hernia        | <input type="checkbox"/> Stomach pain     |
| <input type="checkbox"/> ADHD               | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Passed out          | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> PE tubes in ears    | <input type="checkbox"/> Over weight      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Diabetes/Sugar | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Autism             | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Sickle Cell Trait   |   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Liver trouble       | <input type="checkbox"/> Sickle Cell Disease |   |
| <input type="checkbox"/> Bladder problems   | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Sinus congestion    |   |

**Anemia Risk Assessment:**

Ages 3-5	<input type="checkbox"/> Exposure to Lead	Ages 6-10	<input type="checkbox"/> Strict Vegetarian Diet	Ages 11-21	<input type="checkbox"/> Females after 1st period starts
	<input type="checkbox"/> Poor Growth		<input type="checkbox"/> Poor Growth		<input type="checkbox"/> Males during peak growth spurts
	<input type="checkbox"/> Picky Eater		<input type="checkbox"/> Picky Eater		

Well Child does further lab testing for anemia and glucose(sugar) depending on age and child's health history. These lab tests are performed by a **finger stick** following the American Academy of Pediatrics guidelines.

If you would **NOT** like these tests, please sign here \_\_\_\_\_

**2. Asthma:** How often does your child need to use the inhaler because of wheezing?

\_\_\_\_ Per Week      \_\_\_\_ Per Month      \_\_\_\_ Per Year      \_\_\_\_ Never

Has your child been in the hospital or emergency room for an asthma attack in the past 12 months?

Yes       No        Unknown

**3. Developmental History:**

Did your child have delays in?  None  Unknown

Learning     Walking     Talking     Development (motor skills/learning)     Speech/language

Was your child born early?  Yes     No     Unknown

**4. Current Treatment:** Please check below any service your child is currently receiving:

Development (motor skills/learning)     Speech/language     Other \_\_\_\_\_

**5. Current Medicines:** List over the counter and prescription medicine:  NO MEDICATIONS

**6. Immunizations (shots) up to date?**  Yes  No  Unknown

**7. Family History:** Has anyone in your family had any of the following?  UNKNOWN  NO TO ALL

- |   |  |   |                                      |  |
|---|--|---|--------------------------------------|--|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Stint/Angioplasty/CABG              |
| <input type="checkbox"/> Diabetes/Sugar | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness   | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Sudden death female younger than 65 |
|   |  |   |                                      | <input type="checkbox"/> Sudden death male younger than 55   |

**8. Allergies:**  UNKNOWN  NO ALLERGIES

Medicines     Environment     Penicillin     Peanuts     Shellfish     Bee/Wasp Sting     Latex     Other \_\_\_\_\_

# MEDICAL HISTORY CONTINUED



Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Answer Yes with a

9. **Surgeries or Hospitalizations?**  Yes  No  Unknown If Yes, explain and give dates.

10. **Social/Socioeconomic History:** Number of Children at home? \_\_\_\_\_

Does child have problems in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone smoke in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel your family has enough to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	A working smoke alarm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child regularly drink sodas or fruit drinks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child wear a seat belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a single parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Declined to answer	

11. **Exercise/Elimination:**

How many days a week does your child exercise more than 30 minutes? \_\_\_\_\_ 0-3 days \_\_\_\_\_ 4+ days  
Child's bowel movement:  Normal  Diarrhea \_\_\_\_\_ # of days/week  Hard \_\_\_\_\_ # of days/week

12. **Child Eye Health History:** Has your child had any of the following?  UNKNOWN  NO TO ALL

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Loss of vision/Blindness
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Stye or Chalazion	<input type="checkbox"/> Flashes/Floaters in vision
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Tired Eye	<input type="checkbox"/> Reading difficulty	<input type="checkbox"/> Glared or light sensitivity
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Eye itching	<input type="checkbox"/> Eye turn/Drooping lid	<input type="checkbox"/> Excess watering and tearing
<input type="checkbox"/> Double vision	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Amblyopia/Strabismus	<input type="checkbox"/> Feels like something in the eye
<input type="checkbox"/> Eye Injury: When _____ Which eye _____		<input type="checkbox"/> Eye surgery: When _____ Which eye _____	

13. **Family Eye History:** Has anyone in your family had any of the following?  UNKNOWN  NO TO ALL

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Amblyopia/Strabismus
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye turn/Drooping lid	<input type="checkbox"/> Loss of vision/Blindness

14. **Child Eye Exam:**

Is this your child's first eye exam?  Yes  No Date of last Exam: \_\_\_\_\_  
Does your child wear glasses or contacts?  Yes  No  
Do you have any concerns about your child's vision?  Yes  No

15. **Hearing:**

Does your child say many words?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child speak clearly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child turn the volume up on the TV, radio or headphones too loud?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child follow directions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child say, "huh?" or "what?" a lot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child not answer when you call him/her?	<input type="checkbox"/> Yes <input type="checkbox"/> No

16. **Dental History: (FOR AGES 3, 4, AND 5 ONLY)**

UNKNOWN

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have an allergy to colophony or pine nuts?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever seen a dentist? If yes, when and where?	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you brush your child's teeth? How many times per day?	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you brush your child's teeth with fluoride toothpaste?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you give your child tap water?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child use a bottle?	

## RISK ASSESSMENT QUESTIONNAIRE

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Tuberculosis/HIV Risk Assessment:		Yes	No
1	Has your child been in close contact with a person with infectious tuberculosis?		
2	Does your child live in an established "high risk for tuberculosis" community or area?		
3	Does your child have HIV infection or considered at risk for HIV infection?		
4	Does your child have contact with any of the following: HIV infected homeless, nursing homes, institutionalized individuals, illicit drug users, or migrant farm workers?		
5	Does your child have a poor immune system due to disease or treatment of disease?		
6	Was your child born in Asia, Africa, or Latin America, a refugee or an immigrant?		
Lead - Children 12 months through 5 years ONLY		Yes	No
7	Does your child live in or regularly visit a house/apartment/daycare built before 1950?		
8	Does your child live in or visit a house/apartment/daycare built before 1978 with recent ongoing repairs?		
9	Does your child have a sibling or playmate that has or did have lead poisoning?		
Cholesterol Risk Assessment:			
10	Child History: Has your child had any of the following? <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Overweight		
11	Family History: Has a family member had any of the following? (Parents, grandparents, siblings, aunts, & uncles) <input type="checkbox"/> Heart attack/disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Bypass graft/CABG/Stent/Angioplasty <input type="checkbox"/> Stroke <input type="checkbox"/> Sudden death male younger than 55 <input type="checkbox"/> Sudden death female younger than 65		
<b>Your child may be referred to your primary care physician or to the Health Department if your answers above indicate testing is needed.</b>			

## PEDIATRIC SYMPTOM CHECKLIST 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you can help your child get the best care possible by answering the following questions. Please indicate which statement best describes your child.

		Never	Sometimes	Often
1	Fidgety, unable to sit still			
2	Feels sad, unhappy			
3	Daydreams too much			
4	Refuses to share			
5	Does not understand other people's feelings			
6	Feels hopeless			
7	Has trouble concentrating			
8	Fights with other children			
9	Is down on himself or herself			
10	Blames others for his/her troubles			
11	Seems to be having less fun			
12	Does not listen to rules			
13	Acts as if driven by a motor			
14	Teases others			
15	Worries a lot			
16	Takes things that do not belong to him/her			
17	Distracted easily			
COMMENTS:				

## Pre-Participation Form

Please explain "Yes" answers below.

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**School Name:** \_\_\_\_\_

		Yes	No
1	Has your child ever passed out during exercise?		
2	Has your child ever been dizzy during or after exercise?		
3	Has your child ever had chest pain during exercise?		
4	Does your child tire more quickly than his/her friends during exercise?		
5	Has your child ever had a head injury?		
6	Has your child ever been knocked unconscious?		
7	Has your child ever had a stinger, burner, or pinched nerve?		
8	Has your child ever had heat or muscle cramps?		
9	Has your child ever been dizzy or passed out in the heat?		
10	Does your child have trouble breathing or coughing during or after activities?		
11	Does your child use any special equipment (braces, neck role, eye guard)?		
12	Has any immediate family member died from unexplained causes before they were 50 years old?		
13	Has your child used an asthma inhaler anytime during the past year?		
14	Has your child ever sprained/strained, dislocated, fractured, broken, or had repeated swelling of any bones or joints?		
15	Please explain any of the above "yes" answers here		
<p><b>FEMALES ONLY:</b> What was the longest time between your child's periods during the past year?</p>			

*A physical may be required to participate in school sports and activities. Please check any sports or activities in which your child is interested or will be participating.*

- |                                       |  |                                   |  |
|---------------------------------------|--|-----------------------------------|--|
| <input type="checkbox"/> Band         | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Soccer   | <input type="checkbox"/> Track & Field |
| <input type="checkbox"/> Baseball     | <input type="checkbox"/> Field Hockey  | <input type="checkbox"/> Softball | <input type="checkbox"/> Volleyball    |
| <input type="checkbox"/> Basketball   | <input type="checkbox"/> Football      | <input type="checkbox"/> Swimming | <input type="checkbox"/> Wrestling     |
| <input type="checkbox"/> Bowling      | <input type="checkbox"/> Lacrosse      | <input type="checkbox"/> Tennis   | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> ROTC          |                                   |  |

ONLY FOR AGES 3, 4, 5, 6, AND 7



**PARENTS' EVALUATION OF DEVELOPMENTAL STATUS-REVISED<sup>®</sup>**  
**(PEDS-R<sup>®</sup>) RESPONSE FORM**

\_\_\_\_\_  
Provider

Child's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

Child's Birthday \_\_\_\_\_ Child's Age \_\_\_\_\_ Today's Date \_\_\_\_\_

1. Please list any concerns about your child's learning, development, and behavior.

**COMMENTS:**

2. Do you have any concerns about how your child talks and makes speech sounds?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

3. Do you have any concerns about how your child understands what you say?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

5. Do you have any concerns about how your child uses his or her arms and legs?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

6. Do you have any concerns about how your child behaves?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

7. Do you have any concerns about how your child gets along with others?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

8. Do you have any concerns about how your child is learning to do things for himself or herself?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

9. Do you have any concerns about how your child is learning preschool or school skills?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

10. Do you have any concerns about how your child is behind others or can't do what other kids can?

Would you say you are:    Not concerned?    Concerned?    A little concerned?    **COMMENTS:**

**Keep Going on  
Other Side!**



11. Do you have any concerns about your child's health or about how he or she sees, hears, eats, or sleeps?

Would you say you are: Not concerned? Concerned? A little concerned? COMMENTS:

12. Please list any other concerns.

COMMENTS:

=====**For Office Staff Use Only**=====

Make sure parents have written some comments on the PEDS-R® Response Form and answered all questions. If not, re-administer by interview.

**Prior Screening Results:**

Date of prior screening: \_\_\_\_\_ Risk Level: \_\_\_\_\_ Were any recommended services received? Yes No

\* Make sure clinicians see parents' comments and complete the rest of this form.

=====**For Clinician Use Only**=====

Clinicians, see parents' comments and add your own concerns before scoring. USE PEDS-R® DIRECTIONS TO COMPLETE THE BELOW:

**CURRENT FINDINGS**

<b>PEDS-R® RESULTS</b>	<b>PEDS-R® Path</b>	<b>RISK LEVEL* (check one)</b>
Number of Predictive Concerns _____	A _____	High Risk _____
Number of Non-Predictive Concerns _____	B _____	Moderate Risk _____
	C _____	Low Risk _____
	E _____	

\* If also using PEDS:DM® or an ASD screen (e.g., MCHAT-R), see last page of PEDS-R® directions for assigning risk.

**ACTION STEPS** (check all that apply):

- \_\_\_ give parent advice on development/behavior.  
    \_\_\_ written   \_\_\_ spoken
- Topics: \_\_\_\_\_
- \_\_\_ refer to IDEA or public school special services
- \_\_\_ refer to Head Start/Early Head Start, quality day care, tutoring, after school help
- \_\_\_ refer to medical subspecialties.  
    List: \_\_\_\_\_
- \_\_\_ refer to mental health services
- \_\_\_ refer to parent training program
- \_\_\_ refer to social services (e.g., for housing/food instability)
- \_\_\_ offer anticipatory guidance (e.g., health and safety advice)
- \_\_\_ complete and send 3-way consent form to facilitate referrals
- \_\_\_ ask services to contact family
- \_\_\_ provide parents contact information on services
- \_\_\_ establish date to follow-up with family on effectiveness of advice. Date: \_\_\_\_\_
- \_\_\_ establish date to follow-up with families on enrollment in services. Date: \_\_\_\_\_

**HEALTH CARE: BILLING/CODING** (check all that apply):

- \_\_\_ added appropriate modifiers to E&M code (e.g., - 25, - 59)
- \_\_\_ applied the 96110 screening code showing N of Screens administered (96110 X \_\_\_\_\_)
- \_\_\_ requested enhanced reimbursement via appropriate E&M code (e.g., if FQHC, IHS, RHC)
- \_\_\_ used 96112/96113 (for PEDS:DM® – Assessment Level only)
- \_\_\_ if used, coded/billed for language interpretation service

**Note:** If your clinic needs training, translations, electronic applications, referral resources, parenting handouts, information about PEDS:Developmental Milestones®, videos on PEDS-R® Tools, please visit our website: [www.pedstest.com](http://www.pedstest.com).  
**Or contact us by phone:** (615) 776-4121  
**or by email:** [evpress@pedstest.com](mailto:evpress@pedstest.com)

**This form may not be reproduced. Only completed forms may be scanned.**

## HEALTH SERVICES SURVEY

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dear Parent/Guardian:

**PLEASE COMPLETE ONLY IF YOUR CHILD HAD A WELL CHILD HEALTH EXAM LAST YEAR**

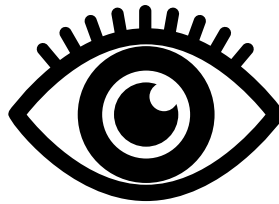
	SURVEY QUESTIONS	Yes	No	Don't Know
<b>1.</b>	Last year, did your child bring home the yellow envelope containing exam results?			
<b>2.</b>	Are you satisfied with the services you received from Well Child?			
<b>3.</b>	Have you seen improvements in your child after using Well Child's services?			
<p style="text-align: center;">If 3 is "Yes", in what areas did you see improvements?</p> <p style="text-align: center;"> <input type="checkbox"/> Attendance             <input type="checkbox"/> Achievement             <input type="checkbox"/> Behavior             <input type="checkbox"/> Health             <input type="checkbox"/> Other         </p>				
<b>4.</b>	Would you like to share a story about your child's Well Child exam?			
<b>5.</b>	Is there any change or improvement you can suggest for the Well Child exam?			
<p style="text-align: center;">If 5 is "Yes", please explain how we can improve our service:</p>				
<b>6.</b>	Would you be interested in telehealth services, an option to help diagnose and treat patients by video conferencing with a nurse, nurse practitioner and/or physician?			

*Thank you for taking the time to complete this important survey. We value our relationship with our families and look forward to continuing to serve your child or children in the future.*



# Well Child™

Physicals and eye exams at school during the school day—available at your school!



**PHYSICALS**

**EYE EXAMS**

**AT SCHOOL**

- No need to miss school or work.
- No need to schedule appointments.
- No need to arrange transportation.

## 3 EASY WAYS TO SIGN UP:

- Call (866) 403-5858 to sign up over the phone.
- Visit [www.wellchild.com](http://www.wellchild.com) to sign up online.
- Complete the attached paper packet and return to school.



**Learn more!**

Follow us @WellChildTN:



Visit [www.wellchild.com](http://www.wellchild.com).



Email [contactus@wellchild.com](mailto:contactus@wellchild.com).



Call (866) 403-5858.