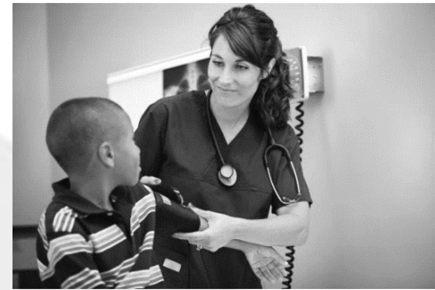
Well Child™

REGION 1 PACKET ENGLISH (T)

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
- Glasses will be fitted and issued to your child at school

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
- Keystone West
- Pittman and Associates
- Tricare
- United Health Care
- 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 1-866-403-5858 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.

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TREATMENT

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

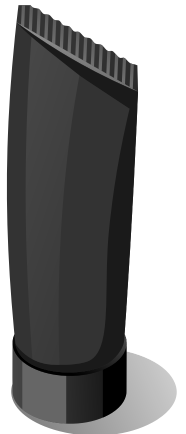
Minor Illnesses

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

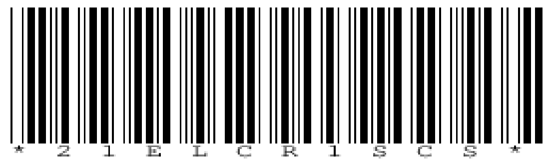
Medication

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 (scan QR code).



Child'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 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.

YEARLY CHECKUP

If you would like a Well Child Yearly Checkup for your child PLEASE SIGN AND DATE below.

SIGN HERE

Date:__________ Parent/Legal Guardian Signature: ________________________________

If you would like Well Child to treat your child for minor illnesses or conditions identified during the Yearly Checkup, PLEASE SIGN AND DATE below.

SIGN HERE

Date:__________ Parent/Legal Guardian Signature: ________________________________

Preferred Pharmacy:________________________________ Phone Number: ___________

Address:____

FLUORIDE 3, 4, or 5 -years-olds only

Fluoride strengthens your child's teeth and decreases tooth decay. Children ages 3, 4, and 5 year may receive up to 2 applications of Fluoride varnish per year.

Please check one below:

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

YEARLY EYE EXAM

If you would like a Well Vision Yearly Eye Exam for your child, PLEASE SIGN AND DATE below.

SIGN HERE

Date: _______ Legal Guardian Signature: ____

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.

To ensure my child's eye health is normal:

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

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It is very important that you complete every question

Name of Child's School ___________________________ Grade ____ Section ____ Teacher ___________

CHILD'S INFORMATION

LAST NAME FIRST M.I.	SEX: ☐ FEMALE ☐ MALE	AGE
ADDRESS	RACE: ☐ ASIAN ☐ BLACK ☐ WHITE ☐ OTHER	
CITY STATE ZIP	ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC	
Main language at home:	Date of Birth ☐☐ – ☐☐ – ☐☐☐☐	
Child's doctor or clinic: Phone Number:		

Well Child will bill your insurance carrier or managed care organization for the exam(s). Circle name of TennCare Provider:

United Health Care Community Plan, TennCare Select, BlueCare, Amerigroup, Other: ___________________________________

Child's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐	TennCare Member ID Number	Tricare DOD Benefit Number

Insurance Company: ___________________________________ Policy: _________________ Group #: ____________________

Policy holder name: ____ Date of Birth: ______________________

***Vision Exams only accept the following insurance carrier: United Health Care (MarchVision), TennCare Select, BlueCare and CoverKIds.**

PARENT/LEGAL GUARDIAN'S INFORMATION

RESPONSIBLE PARTY'S NAME:		RELATIONSHIP TO CHILD:
HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )	CELL PHONE NUMBER ( )
Check preferred method of contact: ☐ Phone	☐ Text	☐ Email
Email Address:		
☐ 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: ( )

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MEDICAL HISTORY

Child's Name: ____ **DOB:**____________________

Answer Yes with a ☑

1. Child's Health History: Has your child had any of the following? ☐ **UNKNOWN** ☐ **NO TO ALL**

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

Anemia Risk Assessment:

Ages 3-5		
	☐	Exposure to Lead
	☐	Poor Growth
	☐	Picky Eater

Ages 6-10		
	☐	Strict Vegetarian Diet
	☐	Poor Growth
	☐	Picky Eater

Ages 11-21		
	☐	Females after 1st period starts
	☐	Males during peak growth spurts

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**

☐ Asthma	☐ Heart Disease	☐ High Cholesterol	☐ Sickle Cell	☐ Stint/Angioplasty/CABG
☐ Diabetes/Sugar	☐ High Blood Pressure	☐ Mental Illness	☐ Stroke	☐ Sudden death female younger than 65
				☐ Sudden death male younger than 55

8. Allergies: ☐ **UNKNOWN** ☐ **NO ALLERGIES**

☐ Medicines ☐ Environment ☐ Penicillin ☐ Peanuts ☐ Shellfish ☐ Bee/Wasp Sting ☐ Latex ☐ Other ________

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MEDICAL HISTORY CONTINUED

Child'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?	☐ Yes	☐ No
Do you feel your family has enough to eat?	☐ Yes	☐ No
Does your child regularly drink sodas or fruit drinks?	☐ Yes	☐ No
Are you a single parent?	☐ Yes	☐ No
Does anyone smoke in the home?	☐ Yes	☐ No
A working smoke alarm?	☐ Yes	☐ No
Does your child wear a seat belt?	☐ Yes	☐ No

☐ 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**

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

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

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Disease
- ☐ Eye turn/Drooping lid
- ☐ Amblyopia/Strabismus
- ☐ Loss of vision/Blindness

14. Child Eye Exam:

Is this your child's first eye exam?	☐ Yes	☐ No
Does your child wear glasses or contacts?	☐ Yes	☐ No
Do you have any concerns about your child's vision?	☐ Yes	☐ No

Date of last Exam: ___________

15. Hearing:

Do you have any concerns about your child's hearing?	☐ Yes	☐ No
Does your child not speak clearly?	☐ Yes	☐ No
Does your child turn the volume up on the TV, radio or headphones too loud?	☐ Yes	☐ No
Does your child not follow directions?	☐ Yes	☐ No
Does your child say, "huh?" or "what?" a lot?	☐ Yes	☐ No
Does your child not answer when you call him/her?	☐ Yes	☐ No

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

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

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RISK ASSESSMENT QUESTIONNAIRE

Child'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? ☐ Diabetes ☐ High Blood Pressure ☐ Overweight		
11	Family History: Has a family member had any of the following? (Parents, grandparents, siblings, aunts, & uncles) ☐ Heart attack/disease ☐ High Cholesterol ☐ Bypass graft/CABG/Stent/Angioplasty ☐ Stroke ☐ Sudden death male younger than 55 ☐ Sudden death female younger than 65		

Your child may be referred to your primary care physician or to the Health Department if your answers above indicate testing is needed.

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:				

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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		
FEMALES ONLY: What was the longest time between your child's periods during the past year?			

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.

- ☐ Band
- ☐ Baseball
- ☐ Basketball
- ☐ Bowling
- ☐ Cheerleading
- ☐ Cross Country
- ☐ Field Hockey
- ☐ Football
- ☐ Lacrosse
- ☐ ROTC
- ☐ Soccer
- ☐ Softball
- ☐ Swimming
- ☐ Tennis
- ☐ Track & Field
- ☐ Volleyball
- ☐ Wrestling
- ☐ Other __________

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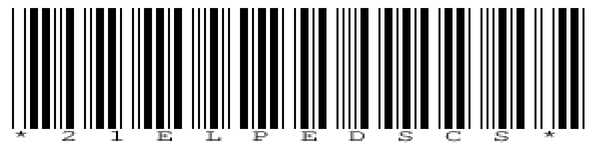
Only for ages 3,4,5,6 and 7



PEDS Response Form

Provider

*Child's Name*____________________ *Parent's Name*____________________

*Child's Birthday*________________ *Child's Age*__________ *Today's Date* ____________

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

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

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

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

Circle one: No Yes A little COMMENTS:

Please list any other concerns.

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