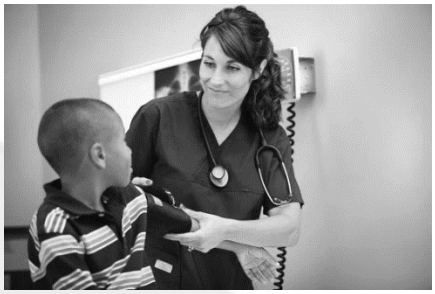
Well Child™

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
- 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 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.

Well Child™

TREATMENT

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

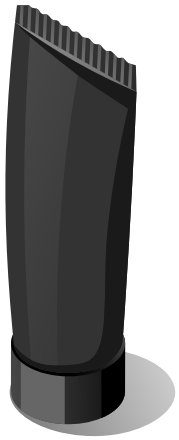
Minor Illnesses

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 (scan QR code).

Scan me

Well Child™

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 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

Parent/Legal Guardian Signature: _____ Date:_____

YEARLY EYE EXAM

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

SIGN HERE

Parent/Legal Guardian Signature: _____ Date:_____

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

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

TREATMENT

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:_____

Well Child™

It is very important that you complete every question.

Name of Sudent's School _____ Grade ____ Section ____ Teacher _____

STUDENT'S INFORMATION

LAST NAME FIRST M.I.	SEX: ☐ FEMALE ☐ MALE	AGE
ADDRESS	RACE: ☐ ASIAN ☐ BLACK ☐ WHITE ☐ OTHER	
CITY STATE ZIP	ETHINICITY: ☐ HISPANIC ☐ NON-HISPANIC	
Main language at home:	Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐	
Student'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_____

Student's Social Security Number	TennCare Member ID Number	Benefit Tricare ID Number
☐☐☐-☐☐-☐☐☐☐		

Insurance Company: _____ Policy #: _____

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 STUDENT:
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: ( )

MEDICAL HISTORY

Well Child™

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**

☐ 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 _____

MEDICAL HISTORY CONTINUED

Well Child™

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?	☐ Yes	☐ No	Does anyone smoke in the home?	☐ Yes	☐ No
Do you feel your family has enough to eat?	☐ Yes	☐ No	A working smoke alarm?	☐ Yes	☐ No
Does your child regularly drink sodas or fruit drinks?	☐ Yes	☐ No	Does your child wear a seat belt?	☐ Yes	☐ No
Are you a single parent?	☐ 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	☐ Retinal Disease	☐ Blurred vision	☐ Loss of vision/Blindness
☐ Cataracts	☐ Dry Eye	☐ Stye or Chalazion	☐ Flashes/Floaters in vision
☐ Eye pain	☐ Tired Eye	☐ Reading difficulty	☐ Glared or light sensitivity
☐ Eye infection	☐ Eye itching	☐ Eye turn/Drooping lid	☐ Excess watering and tearing
☐ Double vision	☐ Eye redness	☐ Amblyopia/Strabismus	☐ Feels like something in the eye
☐ Eye Injury: When _____ Which eye _____		☐ Eye surgery: When _____Which eye _____	

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

☐ Glaucoma	☐ Retinal Disease	☐ Amblyopia/Strabismus
☐ Cataracts	☐ Eye turn/Drooping lid	☐ 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:

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?

Well Child™

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? ☐ 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:				

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 _____

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

PARENTS' EVALUATION OF DEVELOPMENTAL STATUS-REVISED® (PEDS-R®) 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?

ould 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

PEDS-R® RESULTS	PEDS-R® Path	RISK LEVEL* (check one)
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.***

Or contact us by phone: *(615) 776-4121*

or by email: *evpress@pedstest.com*

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
1.	Last year, did your child bring home the yellow envelope containing exam results?			
2.	Are you satisfied with the services you received from Well Child?			
3.	Have you seen improvements in your child after using Well Child's services?			
	If 3 is "Yes", in what areas did you see improvements? ____ Attendance ____ Achievement ____ Behavior ____ Health _____ Other			
4.	Would you like to share a story about your child's Well Child exam?			
5.	Is there any change or improvement you can suggest for the Well Child exam?			
	If 5 is "Yes", please explain how we can improve our service:			
6.	Telehealth is an option to help diagnose and treat patients by video conferencing with a nurse, nurse practitioner and/or physician. May we send you a link to access Well Child Telehealth?			

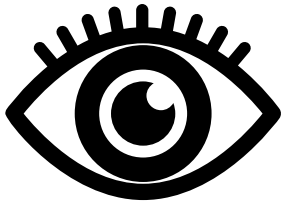
Thank you for taking the time to complete this important survey. We value our relationship with our families and look forward to continuing to serve your child or children in the future.

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 to sign up online.
- Complete the attached paper packet and return to school.

Learn more!

Follow us @WellChildTN:

Visit www.wellchild.com.

Email contactus@wellchild.com.

Call (866) 403-5858.

WC-PGET0320