|  |  |  |
| --- | --- | --- |
|  | WELL CHILD EXAMEARLY ADOLESCENCE:11 – 14 Year | Authority: P.A. 116 of 1973Completion: RequiredConsequences of non-completion:Non-compliance of licensing rules. |
| Michigan Department of Human Services |
| Well Child Exam Date |       |  |
| Patient Name | DOB | Sex | Parent/Guardian Name |
|       |       |       |       |
| Allergies | Current Medications |
|       |       |
| Prenatal/Family History |
|       |
| Weight | Percentile | Length/Height | Percentile | BMI | Percentile | Temp. | Pulse | Resp. | BP (if risk) |
|       |       | % |       | % |       | % |       |       | % |       |       |       |       |

|  |
| --- |
| **Interval History:** |
| (Include injury/illness, visits to other health care providers, changes in family or home) |
|       |
| ***Nutrition*** |  |
| **[ ]**  | Grains |  | servings per day |
| **[ ]**  | Fruit/Vegetables |  | servings per day |
| **[ ]**  | Whole Milk |  | servings per day |
| **[ ]**  | Meat/Beans |  | servings per day |
| **[ ]**  | City water | **[ ]**  | Well water | **[ ]**  | Bottled Water |
| ***Elimination*** | **[ ]**  | Normal | **[ ]**  | Abnormal |
| ***Exercise Assessment*** |  |  |
| Physical Activity |  | minutes per day |
| ***Sleep*** | **[ ]**  | Normal | **[ ]**  | Abnormal |
| ***Menstrual*** |  |
| **[ ]**  | Premenarchal | **[ ]**  | Normal | **[ ]**  | Abnormal |
| Additional area for comments on page 2 |
| **Screening and Procedures** |
| **[ ]**  | Urinalysis (Required for Medicaid sexually active adolescent males and females) |
|  |  |
| ***Hearing*** |  |
| **[ ]**  | Parental observation/concerns |
| ***Vision*** |  |
| **[ ]**  | Visual acuity (at 12 years) |
|  | R |  | L |  | Both |
| **[ ]**  | Parental observation/concerns |
| ***Developmental Surveillance*** |  |
| [ ]  | Social-Emotional | [ ]  | Communicative |
| [ ]  | Cognitive | [ ]  | Physical Development |
| ***Psychosocial/Behavioral Assessment*** |  |
| [ ]  | Yes | [ ]  | No |
| ***Alcohol & Drug Use (risk assessment)*** |  |
| [ ]  | Yes | [ ]  | No |
| ***Screening for Abuse*** | [ ]  | Yes | [ ]  | No |
| ***Screen If At Risk*** |  |
| [ ]  | IPPD |  |  |
| [ ]  | Hct or Hgb |  |  |
| [ ]  | Dyslipidemia |  |  |
| [ ]  | STI Screening |  |  |
| [ ]  | Cervical Dysplasia |  |  |
| [ ]  | Glucose |  |  |
| **Immunizations:** |
| [ ]  | Immunizations Reviewed, Given & Charted |
|  | *– if not given, document rationale* |
| [ ]  | Tdap | [ ]  | HPV | [ ]  | Flu | [ ]  | MCV4 |
| [ ]  | MCIR checked/updated |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Unclothed | [ ]  | Yes | [ ]  | No |
|  | **Review of Systems** | **Physical****Exam** | **Systems** |  |
|  |  |  |  |  |
|  | **N** | **A** | **N** | **A** |  |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | General Appearance |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Skin/nodes |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Head |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Eyes |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Ears |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Nose |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Oropharynx |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Gums/palate |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Neck |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Lungs |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Heart/pulses |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Abdomen |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Genitalia |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Spine |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Extremities/hips |  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | Neurological  |  |
|  |
| [ ]  | Normal Growth and Development |
| [ ]  | Tanner Stage |  |  |
| [ ]  | Abnormal Findings and Comments |
|  | If yes, see additional note area on next page |
|  |
| Results of visit discussed with child/parent |
| [ ]  | Yes | [ ]  | No |
|  |
| **Plan** |
| [ ]  | History/Problem List/Meds Updated |
| [ ]  | Referrals |
|  | [ ]  | Children Special Health Care Needs |
|  | [ ]  | Transportation |  |
|  | [ ]  | Other |  |  |
| [ ]  | Other |  |  |
|  |
| **Anticipatory Guidance/Health Education** |
| (check if discussed) |
| ***Safety*** |  |
| [ ]  | Avoid alcohol, tobacco, drugs, inhalants |
| [ ]  | Make a plan with child if in unsafe situation |
| [ ]  | Seat belt use |
| [ ]  | Swimming/Water Safety |
| [ ]  | Use bike helmet/protective sporting gear |
| [ ]  | Gun and weapon safety |
| ***Nutrition*** |  |
| [ ]  | Limit sugar and high fat food/drinks |
| [ ]  | Healthy weight |
| [ ]  | Offer variety of healthy foods and include 5 servings of fruits & veggies every day |
| [ ]  | Limit TV, video, and computer games |
| [ ]  | Physical activity a& adequate sleep |
| [ ]  | Eat meals as a family |
| ***Oral Health*** |  |
| [ ]  | Schedule dental appointment |
| [ ]  | Brush and floss teeth |
| [ ]  | Limit sweets/soda |
| ***Child Development and Behavior*** |  |
| [ ]  | Discuss puberty, development, contraception, STDs |
| [ ]  | Normal sexual feelings/delaying sex |
| [ ]  | Peer relationships |
| [ ]  | Discuss family & household responsibilities |
| [ ]  | Discuss ways to handle anger/conflict |
| [ ]  | How to handle stress & disappointment |
| ***Family Support and Relationships*** |  |
| [ ]  | Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression |
| [ ]  | Know child’s friends and their families |
| [ ]  | Spend family time together |
| [ ]  | Encourage positive interaction with siblings, teachers, friends and you |
| [ ]  | Discuss limits and consequences |
| [ ]  | Home, school, community rules |
| [ ]  | Discuss school transitions & ability to adapt |
| [ ]  | Encourage participation with peer activities |
| [ ]  | Encourage to volunteer/participate with religious, school or community activities |
|  |
| Next Well Check:  years of age |
| Developmental Surveillance on Page 2Page 3 required for Foster Children |
| Provider Signature: |
|  |

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| PAGE 2 – WELL CHILD EXAM – EARLY ADOLESCENCE: 11 – 14 YEARSDEVELOPMENTAL SURVEILLANCE |
| (This page may be used if not utilizing a Validated Developmental Screener) |
| Date | Patient Name | DOB |
|       |       |       |
|  |
| **Developmental Questions and Observations** |
|  |
| **Ask the parent to respond to the following statements about the child:** |
| **Yes** | **No** |  |
| [ ]  | [ ]  | Please tell me any concerns about the way your child is behaving or developing |
| [ ]  | [ ]  |       |  |
| [ ]  | [ ]  | My child eats breakfast every day. |
| [ ]  | [ ]  | My child is doing well in school. |
| [ ]  | [ ]  | My child has one or more close friends. |
| [ ]  | [ ]  | My child handles stress, anger, frustration well, most of the time. |
| [ ]  | [ ]  | My child seems rested when he/she awakens. |
| [ ]  | [ ]  | My child enjoys at least one activity and/or interest. |
| [ ]  | [ ]  | My child joins in family activities. |
| [ ]  | [ ]  | My child’s activities are supervised by adults I trust. |
| [ ]  | [ ]  |  |
|  |
| **Ask the parent to respond to the following statements:** |
| **Yes** | **No** |  |
| [ ]  | [ ]  | I am proud of my child. |
| [ ]  | [ ]  | I talk to my child about alcohol, drugs, smoking and sex |
|  |
| **Ask the child to respond to the following statements:** |
| **Yes** | **No** |  |
| [ ]  | [ ]  | I feel good about my friends and school. |
| [ ]  | [ ]  | I know what to do when I feel angry, stressed or frustrated. |
| [ ]  | [ ]  | I enjoy school. |
|  |
| \*Please note: Formal development examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents) |
|  |
| Additional Notes from pages 1 and 2: |
|       |
|  |
| Medical Provider Signature | Medical Provider Name (please print) |
|  |  |
| Address | Telephone Number |
|       |       |

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| THIS PAGE IS REQUIED FOR FOSTER CARE CHILDREN |
| PAGE 3 – WELL CHILD EXAM – EARLY ADOLESCENCE: 11 – 14 Years |
|  |
| Date | Child’s Name | DOB |
|       |       |       |
| Name of person who accompanied child to appointment | [ ]  | Parent |
|       | [ ]  | Foster Parent |
| Phone number of person who accompanied child to appointment | [ ]  | Relative Caregiver (specify relationship) |       |
|       | [ ]  | Caseworker |
|  |
| A physical exam, including developmental, psychosocial, and behavioral health screening, must be completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Please attach the completed physical form utilized at this visit. |
|  |
| **Developmental, Psychosocial, and Behavioral Health Screenings (must use validated tool)** |
| Always ask child, parents and/or guardian if they have concerns about development or behavior. (You must use a standardized behavioral instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services). |
|  |
| Validated Standardized Developmental Screening completed: Date |       |  |
|  |
| Screener Used: | **[ ]**  | Pediatric Symptom Checklist (PSC) | **[ ]**  | Pediatric Symptom Checklist-Youth (PSC-Y) |
|  |
|  | [ ]  | Other tool: |       | Score: |       |  |
|  |
| Referral Needed: | [ ]  | No | [ ]  | Yes |  |  |
|  |
| Referral Made: | [ ]  | No | [ ]  | Yes | Date of Referral: |       | Agency: |       |
|  |
| Current or Past Mental Health Services Received: | [ ]  | No | [ ]  | Yes | (if yes please provide name of provider) |
|  |
| Name of Mental Health Provider: |       |
|  |
| EPSDT Abnormal results: |  |
|       |
|  |
| Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.): |  |
|       |
|  |
| Medical Provider Signature | Medical Provider Name (please print) |
|  |  |
| Address | Telephone Number |
|       |       |
|  |
| This form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Department of Human Services, Michigan Association of Health Plans, and Michigan Association of Local Public Health. |
|  |
| Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area. |

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| **PARENT/CAREGIVER HANDOUT**Your Child’s Health at 11 – 14 Years**Milestones**Ways your child is developing between 11 and 14 years of age.* Most children get their second molars (back teeth) between 12 and 13. Talk with your dentist about sealants. Your child should floss daily.
* Between the ages of 10 and 14 many girls will begin to grow breasts and pubic hair and begin their periods.
* Between 10 and 14 many boys will begin to grow pubic hair and they may notice their scrotum and penis begin to change. Their voice may change and they may start to grow facial hair.
* Many boys and girls will have a growth spurt sometime between 10 and 15.
* Your child may have a hard time making good choices and may feel pushed to make bad choices so they feel like they fit in with kids at school.

**For Help or More Information:**Age Specific Safety Information:Call 1-202-662-0600 or go to <http://www.safekids.org/safety-basics/> Domestic Violence hotline:National Domestic Violence Hotline – (800) 700-SAFE (7233) or online at [www.ndvh.org](http://www.ndvh.org) Child sexual abuse, physical abuse, information and support:* Contact the Child Abuse and Neglect Information Hotline or Parents HELPline at 1-800-942-4357.
* The Michigan Coalition Against Domestic & Sexual Violence at 1-517-347-7000 or online at [www.mcadsv.org](http://www.mcadsv.org)
* Childhelp National Child Abuse Hotline 1-800-4-A-CHILD (1-800-422-4453) or online at [www.childhelp.org](http://www.childhelp.org)

Information for teens and their parents:Provides information for teens and parents of teen on many teen topics. <http://www.kidshealth.org/> Sexuality Information for teens::(Planned Parenthood®) http://www.plannedparenthood.org/info-for-teens/index.aspChildren’s Mental Health parent support and advocacy:Contact the Association of Children’s Mental Health (ACMH) at 1-888-ACMH-KID (226-4543) or online at [www.acmh.mi.org](http://www.acmh.mi.org) Churches or schools in your area may give classes on how to handle conflicts and/or anger. These can be useful skills for young teenagers. | **Health Tips**Growth happens at different times for everyone. This can worry a child. If your child has not begun to have growth changes by age 14 talk with the doctor.Your child will need shots at this age. Talk with your child’s doctor and make sure your child has had all of her shots.Your child should have a goal to be physically active at least 60 minutes each day. It doesn’t have to be all at once. Find activities that you and your child enjoy. This is an important habit for your child to learn.It is important that your child eat healthy foods and snacks. Keep healthy snacks available. Your child needs fruit, vegetables, juice, and whole grains for growth and energy.**Parenting Tips:**Talk with your child about the changes in her body before and as the changes happen. Tell her these are signs of growing up and it can be exciting but can also be scary.Your child may be more emotional and sometimes rude or angry. Sometimes he feels sad, nervous or worried and things may not be going right. Talk with your child about his feelings Help him find a counselor if needed.Talk with and let your child know that sexual feelings are normal, but to delay having sex.Your child is growing mentally. You can help her thinking skills by asking her to solve problems.Talk about why teenagers should not use drugs and alcohol. Set a good example for your child.Teach your child how to deal with peer pressure.Encourage your child to join school or sporting activities.**Safety Tips**Cigarettes, drugs and alcohol are often offered to teenagers. Practice “saying no” with your child.Teach your child gun safety. If you keep guns or rifles in your home, make sure they are unloaded and locked up.Teach your child to walk away if they see someone with a gun or other weapon and then report it to an adult they trust.Teach your child to always wear a seatbelt in the car and to sit in the back seat until they are adult height and weight.It’s important for your child to use the correct sports equipment and safety gear. Make sure it fits your child well. |
|  |
| From the Institute for Health Care Studies at Michigan State University. |
|  |
| Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area. |