

*This checklist is designed to help you get the right preventive healthcare and give you more control over your child's care.  
Please share this checklist with your child's doctor at every visit. Your doctor can help you fill in the chart.*

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_

### Prevention Screenings, Tests and Education Checklist

<b>Prevention and Screenings</b>			<b>Additional Details:</b>
<input type="checkbox"/> Six or more well-child visits in first 15 months of life	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> One well-child visit in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> and 6 <sup>th</sup> year of life	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> One adolescent well-care visit every year	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
 			_____
<input type="checkbox"/> <b>Child/Adolescent weight assessment and counseling for nutrition and physical activity every year</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
 			_____
<input type="checkbox"/> <b><u>Childhood immunizations by 2<sup>nd</sup> birthday (combo 10)</u></b>			_____
• Four DTaP	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Three polio (IPV)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• One measles, mumps & rubella (MMR)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Three H influenza type B (HIB)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Three hepatitis B (HepB)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• One chicken pox (VZV)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Four pneumococcal conjugate (PCV)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• One hepatitis A (HepA)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Two or three rotavirus (RV)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
• Two influenza (flu)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> <b>Lead screening by 2<sup>nd</sup> birthday</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	<b>Result:</b> _____
<input type="checkbox"/> <b>Human Papillomavirus for female adolescents (HPV) Three vaccinations between 9<sup>th</sup> &amp; 13<sup>th</sup> birthday</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	<b>Result:</b> _____
<input type="checkbox"/> <b>Appropriate testing for children with pharyngitis (age 2-18)</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	
• Given an antibiotic and receives a group A strep test			
<input type="checkbox"/> <b>Appropriate treatment for children with upper respiratory infection (age 3 months -18 years)</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	
• Diagnosed with upper respiratory infection and is not given an antibiotic prescription			
<input type="checkbox"/> <b>Appropriate controller asthma medication (oral medication, inhaler or injection dispensing events).</b>	<input type="checkbox"/> <i>Completed</i>	Date: _____	<b>Name of RX prescribed :</b> _____ _____ _____

