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

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

Child