

**WELL CHILD EXAM
EARLY ADOLESCENCE:
11 – 14 Year**

Michigan Department of Human Services

Authority: P.A. 116 of 1973
Completion: Required
Consequences of non-completion:
Non-compliance of licensing rules.

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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 2
Page 3 required for Foster Children

Provider Signature: _____

**PAGE 2 – WELL CHILD EXAM – EARLY ADOLESCENCE: 11 – 14 YEARS
DEVELOPMENTAL SURVEILLANCE**

(This page may be used if not utilizing a Validated Developmental Screener)

Date	Patient Name	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Please tell me any concerns about the way your child is behaving or developing |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | My child eats breakfast every day. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child is doing well in school. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child has one or more close friends. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child handles stress, anger, frustration well, most of the time. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child seems rested when he/she awakens. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child enjoys at least one activity and/or interest. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child joins in family activities. |
| <input type="checkbox"/> | <input type="checkbox"/> | My child's activities are supervised by adults I trust. |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Ask the parent to respond to the following statements:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I am proud of my child. |
| <input type="checkbox"/> | <input type="checkbox"/> | I talk to my child about alcohol, drugs, smoking and sex |

Ask the child to respond to the following statements:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I feel good about my friends and school. |
| <input type="checkbox"/> | <input type="checkbox"/> | I know what to do when I feel angry, stressed or frustrated. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

**THIS PAGE IS REQUIRED 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	<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent	
Phone number of person who accompanied child to appointment	<input type="checkbox"/> Relative Caregiver (specify relationship) <input type="checkbox"/> 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,

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.

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

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
- Childhelp National Child Abuse Hotline 1-800-4-A-CHILD (1-800-422-4453) or online at 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.asp>

Children'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

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.

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