Name____________________ Date__________ 6 Year screening

	Yes	No	Unsure
1. Does your child have a sibling or playmate who has or has had lead poisoning?			
2. Is your child often in a home built before 1978 that's been remodeled in the last 6 months?			
3. Does your child live in a home or attend a daycare built before 1950?			
4. Has a family member or contact had TB (Tuberculosis) or a positive TB skin test?			
5. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?			
6. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
7. Does your child have HIV/AIDS?			
8. Do you have concerns that your child does NOT eat enough iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
9. Have your child's parents or grandparents had a stroke or heart problem before age 55?			
10. Does your child have a parent with high cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?			
11. Does your child mainly eat a vegetarian or vegan diet?			
12. Do you feel you have difficulties providing enough food to feed your family?			
13. Is your child ever around tobacco smoke?			

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14. Is your child toilet trained in the daytime?			
15. Is your child toilet trained through the night?			

Oral Health Assessment	**Yes**	**No**	**Unsure**
1. Does your child's main source of drinking water contain fluoride? (None of the cities in Southern Oregon add fluoride to the city water, unlike the rest of the country.			
2. Does your child drink juice, soda, sports drinks or sugary foods more than once a week?			
3. Have you or your child's primary caregiver had active decay in the last 12 months?			

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1. Does your child visit the dentist twice a year?			
2. Does your child receive topical sources of fluoride such as varnish, toothpaste or mouth rinse?			
3. Does your child receive fluoride supplements such as drops or chewables?			
4. Do you brush your child's teeth at least twice a day?			
5. Do you or your child's primary caregiver have a dentist?			
6. Has your child received fluoride varnish in the last 6 months?			

Developmental Screen: Does your child do the following	**Yes**	**No**	**Unsure**
1. No concerns, talks well and responds to conversation?			
2. Hops, jumps forward and balances on 1 foot?			
3. Skips, can walk on tiptoes, broad jumps?			
4. Copies a triangle?			
5. Draws a person with head, body, arms and legs?			
6. Beginning to understand right and wrong?			
7. Knows 4-5 colors?			
8. Dresses and undresses without supervision?			
9. States age?			