

**IMPORTANT: Always bring this booklet when you visit any health clinic, doctor or hospital**

# ROAD TO HEALTH BOYS

Child's first name and surname:

---

Date of Birth:

---

DD/MM/YYYY

---

This booklet must be issued at birth by the health services concerned.

If birth takes place at home, the first opportunity after delivery should be used to issue the booklet.

The booklet must be issued **FREE OF CHARGE**, irrespective of delivery taking place at a public or private health facility.



**health**

Department:  
Health  
**REPUBLIC OF SOUTH AFRICA**

## WELL CHILD VISITS – RECORDING SHEET FOR CHILDREN

Record the following information for each visit on the spaces that are not shaded. Refer to the page numbers given in this booklet and complete the relevant section.

| Age      | Date | Growth<br>(IMCI)<br>(page 14) | PMTCT/<br>HIV<br>status<br>(IMCI)<br>(page<br>7&8) | TB<br>status<br>(IMCI) | Remember to check the following. Tick if done, and record details on the relevant page |  |  |  |  |  |  |  |  |  | Date of next visit |
|----------|------|-------------------------------|--|------------------------|--|--|--|--|--|--|--|--|--|--|--------------------|
|          |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 3-6 days |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 6 wks    |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 10 wks   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 14 wks   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 4 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 5 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 6 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 7 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 8 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 9 mths   |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |
| 10 mths  |      |                               |  |                        |  |  |  |  |  |  |  |  |  |  |                    |

| Age     | Date | Growth<br><b>(IMCI)</b><br>(page 14) | PM/CT/<br>HIV<br>status<br><b>(IMCI)</b><br>(page 7&8) | TB<br>status<br><b>(IMCI)</b> | Feeding<br>(EBF/IEFF/<br>mixed<br>feeding<br>for first 6<br>months) | Immunisations<br>(page 6 ) | Vitamin A | Development<br>(page 9) | Develompment<br>(page 13) | Oral Health<br>(page 20) | Date of<br>next visit |
|---------|------|--------------------------------------|--|-------------------------------|---|----------------------------|-----------|-------------------------|---------------------------|--------------------------|-----------------------|
| 11mths  |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 12 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 14 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 16 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 18 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 20 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 22 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 24 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 30 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 36 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 42 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 48 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 54 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 60 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 72 mths |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |
| 12 yrs  |      |                                      |  |                               |   |                            |           |                         |                           |                          |                       |

| <b>DETAILS OF CHILD AND FAMILY (To be completed at birth)</b>   |   |   |                              |                             |
|---|---|---|------------------------------|-----------------------------|
| Child's first name and surname: _____   |   |   |                              |                             |
| Child's ID number:  | <input type="text"/> |   |                              |                             |
| Mother's ID number:   | <input type="text"/> |   |                              |                             |
| Date of birth<br>dd mm yyyy   | / /   | Name of facility where child was born:                                      |                              |                             |
| Child's residential address:  |   |   |                              |                             |
| Mother's name:  | Mother's birth date:  |   |                              |                             |
| Father's name:  | Who does the child live with?   |   |                              |                             |
| How many children has the mother had (including this child?)  |   |   |                              |                             |
| Number born<br>(including stillbirths)  | <input type="text"/>  | Reason(s) for death(s):   |                              |                             |
| Number alive now  | <input type="text"/>  | Date information given: / /<br>dd mm yyyy                                   |                              |                             |
| <b>Child in need of special care (mark with X)</b><br>(Complete at delivery or at first contact with health services) |   |   |                              |                             |
| Is the baby a twin, triplet, etc?   | <input type="checkbox"/> Yes  | Does the mother need additional support to care for the child?<br>(Specify) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any disability present<br>(including birth defects?)<br>(Specify)   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   | Other:<br>(Specify)          |                             |
| Stamp of facility and name and signature of official who issued booklet   |   |   |                              |                             |

## **IMMUNISATIONS**

| Name and surname: |           |               | ID number:<br> |                     |           |
|-------------------|-----------|---------------|--|---------------------|-----------|
| Age group         | Batch no. | Vaccine       | Site   | Date given dd/mm/yy | Signature |
| Birth             |           | BCG           | Right arm  |                     |           |
|                   |           | OPV0          | Oral   |                     |           |
| 6 weeks           |           | OPV1          | Oral   |                     |           |
|                   |           | RV1           | Oral   |                     |           |
|                   |           | DTaP-IPV-Hib1 | Left thigh   |                     |           |
|                   |           | Hep B1        | Right thigh  |                     |           |
|                   |           | PCV 1         | Right thigh  |                     |           |
| 10 weeks          |           | DTaP-IPV-Hib2 | Left thigh   |                     |           |
|                   |           | Hep B2        | Right thigh  |                     |           |
| 14 weeks          |           | DTaP-IPV-Hib3 | Left thigh   |                     |           |
|                   |           | Hep B3        | Right thigh  |                     |           |
|                   |           | PCV2          | Right thigh  |                     |           |
|                   |           | RV2           | Oral   |                     |           |
| 9 months          |           | Measles1      | Left thigh   |                     |           |
|                   |           | PCV3          | Right thigh  |                     |           |
| 18 months         |           | DTaP-IPV-Hib4 | Left arm   |                     |           |
|                   |           | Measles2      | Right arm  |                     |           |
| 6 years           |           | Td            | Left arm   |                     |           |
| 12 years          |           | Td            | Left arm   |                     |           |
|                   |           |               |  |                     |           |
|                   |           |               |  |                     |           |
|                   |           |               |  |                     |           |

#### **HEAD CIRCUMFERENCE AT 14 WEEKS AND AT 12 MONTHS**

**14 Weeks:** (Range: 38 - 43 cm) **12 Months:** (Range: 43.5 - 48.5)

REFER if head circumference is outside range.

| <b>NEONATAL INFORMATION</b>  |               |  |  |
|--|---------------|--|--|
| Birth weight:  | Birth length: | Head circumference at birth:             |  |
| Gestational age (weeks)  | Rh factor     | Mother's RPR                             |  |
| Antenatal (Maternal history):  |               | Intrapartum (including mode of delivery) |  |
| <b>APGAR</b>   | 1 min         | 5 min                                    |  |
| Neonatal problems: (identify high risk problems):  |               |  |  |
| Neonatal Feeding: <input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula |               |  |  |
| Special care plan / input required (e.g. Kangaroo Mother Care)   |               |  |  |
| Specify:   |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |
| Post-discharge plan (if baby was admitted in a neonatal ward/premature):                               |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |
|  |               |  |  |

## PMTCT/HIV INFORMATION

Child's first name and surname:

Child's ID Number:

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|

Signature of consent:

Date:

**Fill in this section on discharge from Midwife Obstetric Unit (MOU) or obstetric ward or at first subsequent visit if not yet done**

|   |   |   |   |
|---|---|---|---|
| Mother's latest HIV test result                       | <input type="checkbox"/> Positive         | <input type="checkbox"/> Negative         | <input type="checkbox"/> To be done       |
| When did mother have the test?                        | <input type="checkbox"/> Before pregnancy | <input type="checkbox"/> During pregnancy | <input type="checkbox"/> At delivery      |
| Is the mother on life-long ART?                       | <input type="checkbox"/> Yes              | <input type="checkbox"/> No               |   |
| If yes, duration of life-long ART at time of delivery | <input type="checkbox"/> < 4 weeks        | <input type="checkbox"/> > 4 weeks        | <input type="checkbox"/> Before pregnancy |

Document ARVs the mother received:

|   |   |  |
|---|---|--|
| Did the mother receive infant feeding counseling? | <input type="checkbox"/> Yes              | <input type="checkbox"/> No                |
| Decision about infant feeding                     | <input type="checkbox"/> Exclusive breast | <input type="checkbox"/> Exclusive formula |

Document Nevirapine given:

**All HIV exposed infants should receive Nevirapine for a minimum of 6 weeks**

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Has the mother disclosed to anyone in the household? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the mother's partner been tested?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Remember to offer testing for all the mother's other children if not yet done**

Offer a mother with unknown HIV status a rapid HIV test.

If mother's HIV rapid test is positive, perform an HIV DNA PCR test on infant if  $\geq 6/52$

| <b>Fill in this section if infant is HIV exposed</b>  |  |  |                                   |                                   |   |                                   |                                   |                                   |
|---|--|--|-----------------------------------|-----------------------------------|---|-----------------------------------|-----------------------------------|-----------------------------------|
| <b>6 week visit</b>   |  |  |                                   |                                   |   |                                   |                                   |                                   |
| What feeds has the infant received?   |  |  | <input type="checkbox"/>          | Exclusive breast                  | <input type="checkbox"/>                  | Exclusive formula                 | <input type="checkbox"/>          | Mixed feeding                     |
| HIV PCR test done?<br>Date:   |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       | Affix NHLS tracking barcoded sticker here |                                   |                                   |                                   |
| Cotrimoxazole started?  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Infant feeding discussed?   |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Has the child received Nevirapine?  |  |  | If yes:                           |                                   | <input type="checkbox"/> Stop now         | <input type="checkbox"/> Continue |                                   |                                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                   |                                   |   |                                   |                                   |                                   |
| <b>Stop Nevirapine if the mother is on life-long ART or the child has stopped breastfeeding. If not, continue until breastfeeding stops</b>   |  |  |                                   |                                   |   |                                   |                                   |                                   |
| <b>10 week visit, or earlier if ill</b>   |  |  |                                   |                                   |   |                                   |                                   |                                   |
| PCR result  |  |  | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative |   |                                   |                                   |                                   |
| Post test counseling done?  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Referred for ART?   |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       | Stop Nevirapine if PCR is positive        |                                   |                                   |                                   |
| Cotrimoxazole given?  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Has child received Nevirapine?  |  |  | If yes:                           |                                   | <input type="checkbox"/> Stop now         | <input type="checkbox"/> Continue |                                   |                                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                   |                                   |   |                                   |                                   |                                   |
| Encourage a mother whose baby is HIV positive to continue breastfeeding   |  |  |                                   |                                   |   |                                   |                                   |                                   |
| <b>Retest HIV negative children 6 weeks after cessation of breastfeeding, or if clinical suspicion.</b><br><b>An HIV exposed child should be retested with a rapid HIV Antibody test at 18 months</b> |  |  |                                   |                                   |   |                                   |                                   |                                   |
| Repeat PCR test   |  |  | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative | HIV antibody test                         |                                   | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative |
| Date:   |  |  |                                   |                                   | Date:                                     |                                   |                                   |                                   |
| Post test counseling done?  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Referred for ART  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       | Stop Nevirapine if PCR is positive        |                                   |                                   |                                   |
| Cotrimoxazole given?  |  |  | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |   |                                   |                                   |                                   |
| Has child received Nevirapine?  |  |  | If yes:                           |                                   | <input type="checkbox"/> Stop now         | <input type="checkbox"/> Continue |                                   |                                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                   |                                   |   |                                   |                                   |                                   |
| Tick if there is additional information on HIV status in clinical notes   |  |  |                                   |                                   |   |                                   |                                   |                                   |

| <b>VITAMIN A SUPPLEMENTATION</b>   |               |                            |                  |               |                            |                  |
|--|---------------|----------------------------|------------------|---------------|----------------------------|------------------|
|  | <b>At age</b> | <b>Date given dd/mm/yy</b> | <b>Signature</b> | <b>At age</b> | <b>Date given dd/mm/yy</b> | <b>Signature</b> |
| 100 000 IU   | 6 mths        | / /                        |                  |               |                            |                  |
| 200 000 IU<br>every 6 months   | 12 mths       | / /                        |                  | 42 mths       | / /                        |                  |
|  | 18 mths       | / /                        |                  | 48 mths       | / /                        |                  |
|  | 24 mths       | / /                        |                  | 54 mths       | / /                        |                  |
|  | 30 mths       | / /                        |                  | 60 mths       | / /                        |                  |
|  | 36 mths       | / /                        |                  |               |                            |                  |
| <b>ADDITIONAL DOSES:</b>   |               |                            |                  |               |                            |                  |
| <p>For conditions such as measles, severe malnutrition, xerophthalmia and persistent diarrhoea. Omit if dose has been given in last month.</p> <p>Measles and xerophthalmia: Give one dose daily for two consecutive days. Record the reason and dose given below.</p> |               |                            |                  |               |                            |                  |
| Date   | Dose given    | Reason                     | Signature        | Date          | Dose given                 | Reason           |
|  |               |                            |                  |               |                            |                  |
|  |               |                            |                  |               |                            |                  |
|  |               |                            |                  |               |                            |                  |
| <b>DEWORMING TREATMENT (Mebendazole or Albendazole)</b>  |               |                            |                  |               |                            |                  |
| Dose   | <b>At age</b> | <b>Date given dd/mm/yy</b> | <b>Signature</b> | <b>At age</b> | <b>Date given dd/mm/yy</b> | <b>Signature</b> |
|  | 12 mths       | / /                        |                  | 18 mths       | / /                        |                  |
|  | 24 mths       | / /                        |                  | 48 mths       | / /                        |                  |
|  | 30 mths       | / /                        |                  | 54 mths       | / /                        |                  |
|  | 36 mths       | / /                        |                  | 60 mths       | / /                        |                  |
|  | 42 mths       | / /                        |                  |               |                            |                  |

## HEALTH PROMOTION MESSAGES

### Up to 6 months

Feeding:

- Breastfeed exclusively (give infant only breast milk and no other liquids or solids, not even water, with exception of drops or syrup consisting of vitamins, mineral supplements or medication);
- Breastfeed as often as the child wants, day and night;
- Feed at least 8 to 12 times in 24 hours;
- When away from the child leave expressed breast milk to feed with a cup;
- Avoid using bottles or artificial teats (dummies) as this may interfere with suckling, be difficult to clean and may carry germs that can make your baby sick.



**Why is exclusive breastfeeding important?**

- Other foods or fluids may damage a young baby's gut and make it easy for infections (including HIV) to get into the baby's body;
- Decreases the risk of diarrhoea;
- It decreases risk of respiratory infections;
- It decreases risk of allergies;

**If you have chosen to formula feed your baby, discuss safe preparation and use of formula with the health care worker**

**Play:** Provide ways for your child to see, hear, feel, and move.  
Have colorful things to see and reach

**Communicate:** Look into your child's eyes and smile at him or her  
Talk to your child and get a conversation going with sounds or gestures.



## HEALTH PROMOTION MESSAGES

### 6 - 12 months

#### Feeding:

**For all children start complementary foods at 6 months**



- ◆ Continue breastfeeding;
- ◆ Always breastfeed first before giving complementary foods;
- ◆ Start giving 2–3 teaspoons of mashed dried beans and/or locally available animal foods daily to supplement the iron in the breastmilk. Examples include egg (yolk), minced meat, fish, chicken/chicken livers, mopani worms. Give soft porridge, vegetables and then fruit;
- ◆ Gradually increase the amount and frequency of feeds.
- ◆ Children between 6–8 months should have two meals a day. By 12 months this should have increased to 5 small meals per day, whilst frequent breastfeeding continues;
- ◆ Offer your baby safe, clean water regularly;
- ◆ If the baby is not breastfed, give formula or at least 2 cups of full cream cow's milk (cow's milk can be given from 9 months of age)

Play: Give your child clean household things to handle, bang and drop.



#### Communicate:

Respond to your child's sounds and interests. Tell your child the names of things and people.

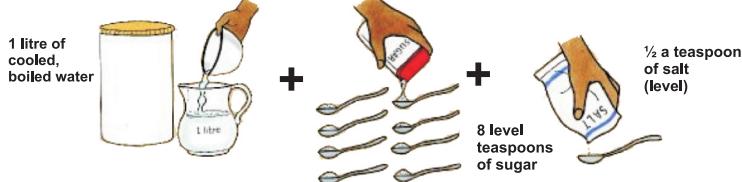
#### Encourage feeding during illness

Suggest an extra meal a day for a week after getting better

## Feeding recommendation for DIARRHOEA

- ◆ Follow feeding recommendations for the child's age, but give small frequent meals (at least 6 times a day);
- ◆ Give a sugar-salt solution (SSS) in addition to feeds. Give SSS after each loose stool, using frequent small sips from a cup (half cup for children under 2 years and 1 cup for children 2–5 years). If the child vomits, wait for 10 minutes then continue, but more slowly

#### How to prepare a sugar-salt solution (SSS) at home



## HEALTH PROMOTION MESSAGES

### Feeding: 12 months up to 5 years

- If the child is breastfed, continue breastfeeding as often as the child wants until the child is 2 years and beyond;
- If not breastfeeding, give at least 2 cups of full cream milk, which could be maas, every day;
  - Encourage children to eat a variety of foods;
  - Feed your children five small meals a day;
  - Make starchy foods the basis of a child's main meals;
  - Children need plenty of vegetables and fruit every day;
  - Children can eat chicken, fish, eggs, beans, soya or peanut butter every day;
  - Give foods rich in iron and vitamins A and C;
- **Iron-rich foods:** Liver, kidney, dark green leafy vegetables, egg yolk, dry beans, fortified cereal; Remember that tea interferes with the absorption of iron. Iron is best absorbed in the presence of vitamin C;
- **Vitamin A-rich foods:** Liver, dark green leafy vegetables, mango, paw paw, yellow sweet potato, full cream milk;
- **Vitamin C-rich foods:** Citrus fruit (oranges, naartjies), guavas, tomatoes;
- If children have sweets, treats or drinks, offer small amounts with meals;
- Offer clean, safe water regularly;
- Encourage children to be active every day.



### Play and communicate: 12 months to 2 years

- Play: Give your child things to stack up, and to put into containers and take out.
- Play: Help your child count, name, and compare things.
- Play: Make simple toys for your child.

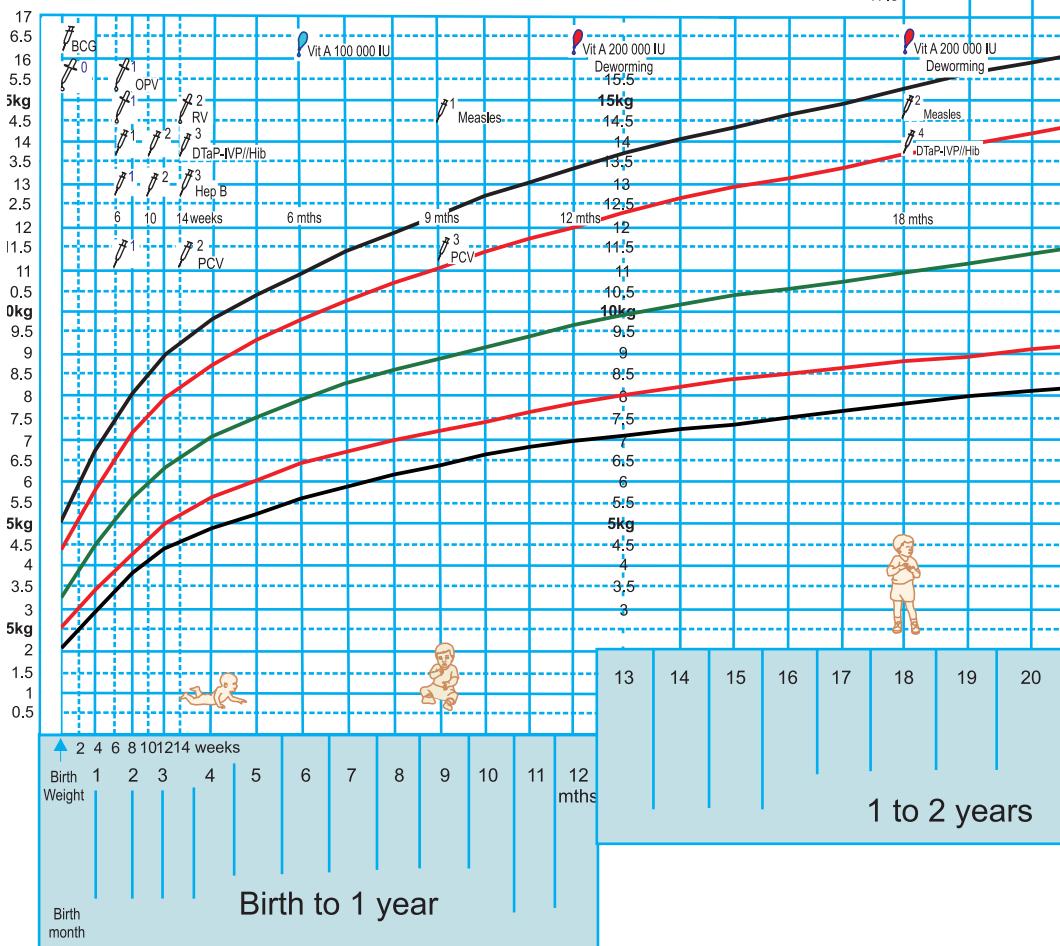
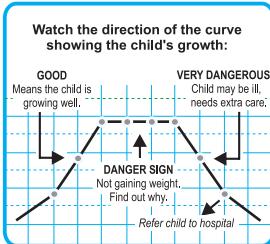
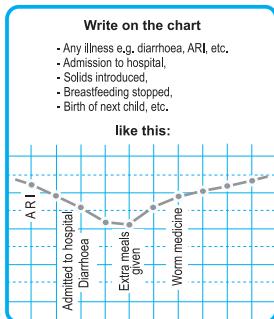


### Play and communicate: Above 2 years

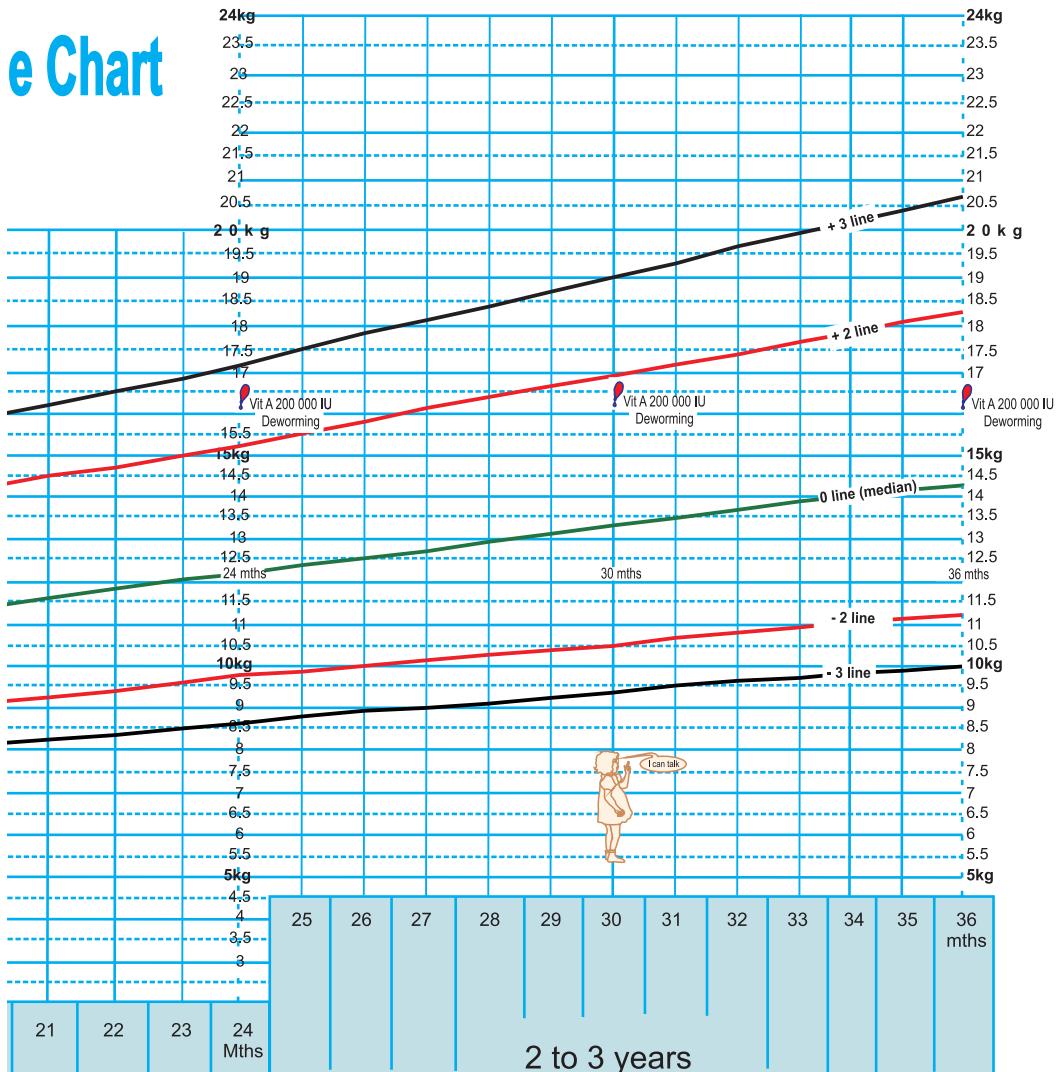
- Communicate: Ask your child simple questions. Respond to your child's attempts to talk. Play games like "bye".
- Communicate: Encourage your child to talk and answer your child's questions. Teach your child stories, songs and games.

| DEVELOPMENTAL SCREENING        |  |   |  |
|--------------------------------|--|---|--|
|                                | VISION AND ADAPTIVE  | HEARING AND COMMUNICATION   | MOTOR DEVELOPMENT  |
| ALWAYS ASK                     | Can your child see?  | Can your child hear and communicate as other children?  | Does your child do the same things as other children of the same age?  |
| 14 weeks                       | Baby follows close objects with eyes   | Baby responds to sound by stopping sucking, blinking or turning   | Child lifts head when held against shoulder<br>       |
| 6 months                       | Baby recognises familiar faces   | Child turns head to look for sound  | Child holds a toy in each hand<br>                     |
| 9 months                       | Child's eyes focus on far objects<br><br>Eyes move well together (No squint)   | Child turns when called   | Child sits and plays without support<br>              |
| 18 months                      | Child looks at small things and pictures   | Child points to 3 simple objects<br><br>Child uses at least 3 words other than names<br><br>Child understands simple commands | Child walks well<br><br>Child uses fingers to feed   |
| 3 years                        | Sees small shapes clearly at 6 metres  | Child speaks in simple 3 word sentences   | Child runs well and climbs on things   |
| 5-6 years:<br>School readiness | No problem with vision, use a Snellen E chart to check   | Speaks in full sentences and interact with children and adults  | Hops on one foot<br><br>Able to draw a stick person |
| REFER                          | Refer the child to the next level of care if child has not achieved the developmental milestone. Refer motor problem to Occupational Therapist/Physiotherapist and hearing and speech problem to Speech therapist/Audiologist if you have the services at your facilities. |   |  |

# Boy's Weight-for-Age



# e Chart



## 2 to 3 years

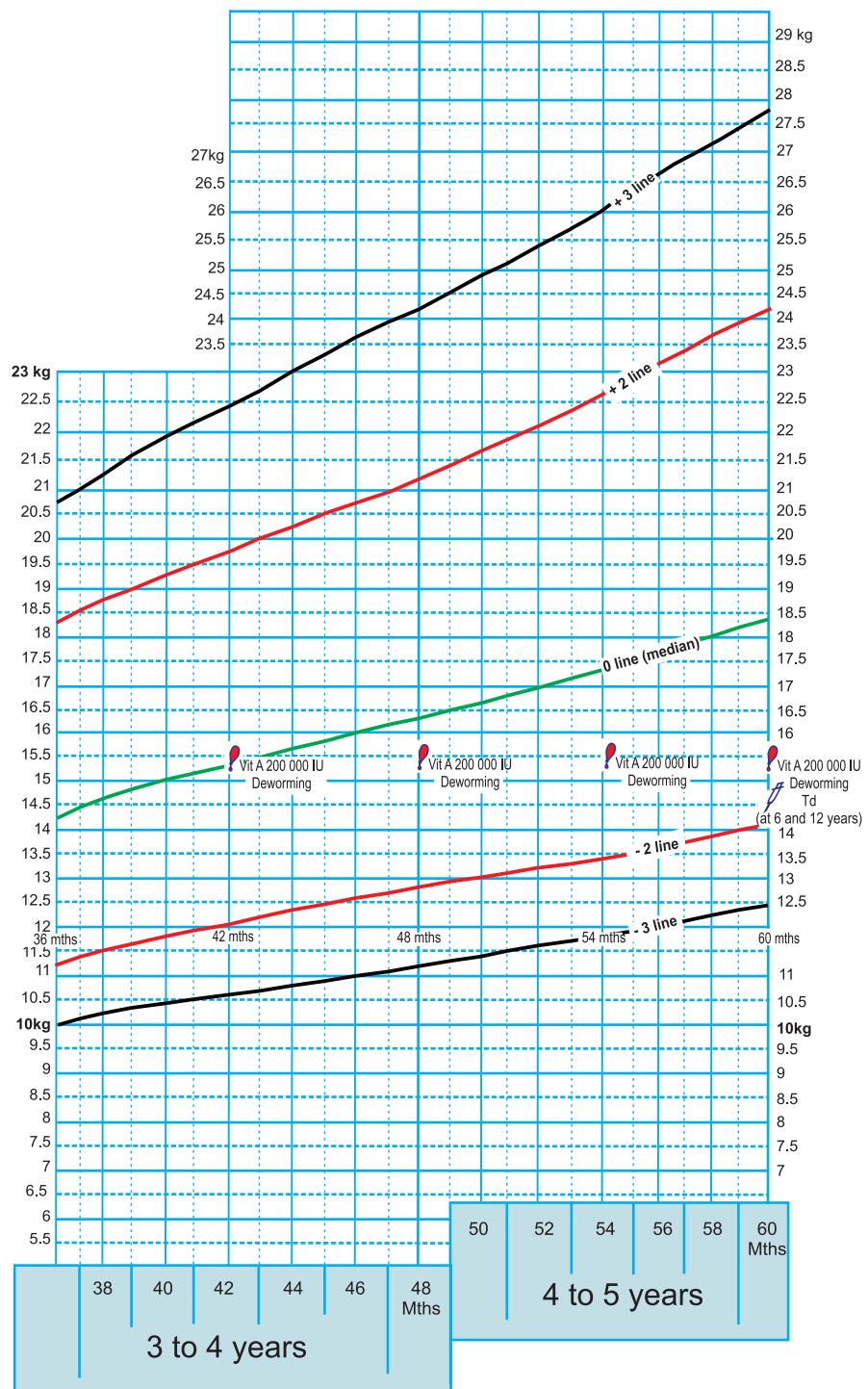
### Interpretation of lines:

This Weight-for-Age Chart shows body-weight relative to age in comparison to the Median (0-line).

A boy whose weight-for-age is below the -2 line, is underweight.  
A boy whose weight-for-age is below the -3 line, is severely underweight. Clinical signs of Marasmus or Kwashiorkor may be observed.

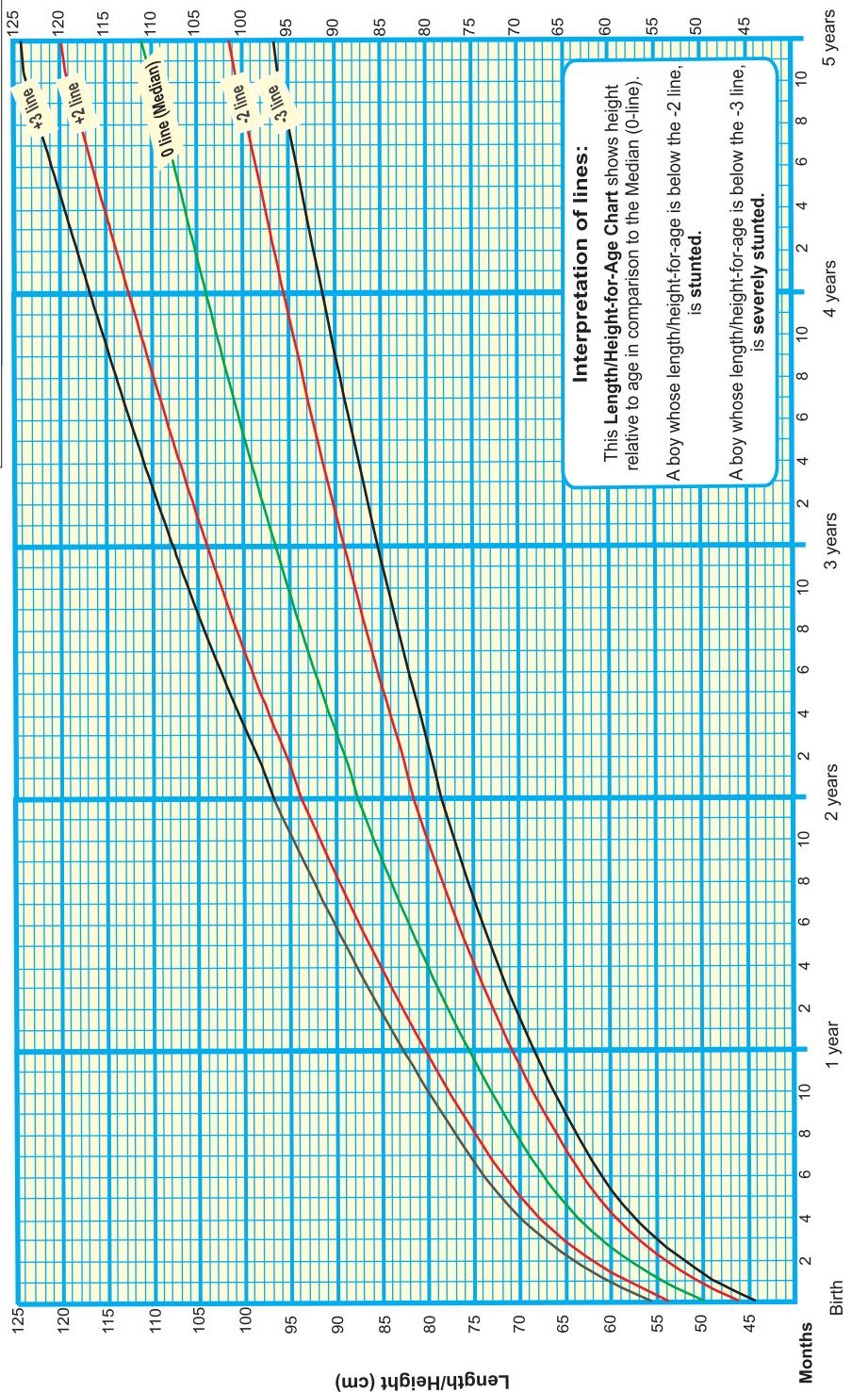
If his line crosses a z-score line and the shift is away from the median, this may indicate a problem or risk of a problem.

If his line stays close to the median, occasionally crossing above or below it, this is



# Length/height -for-age BOYS

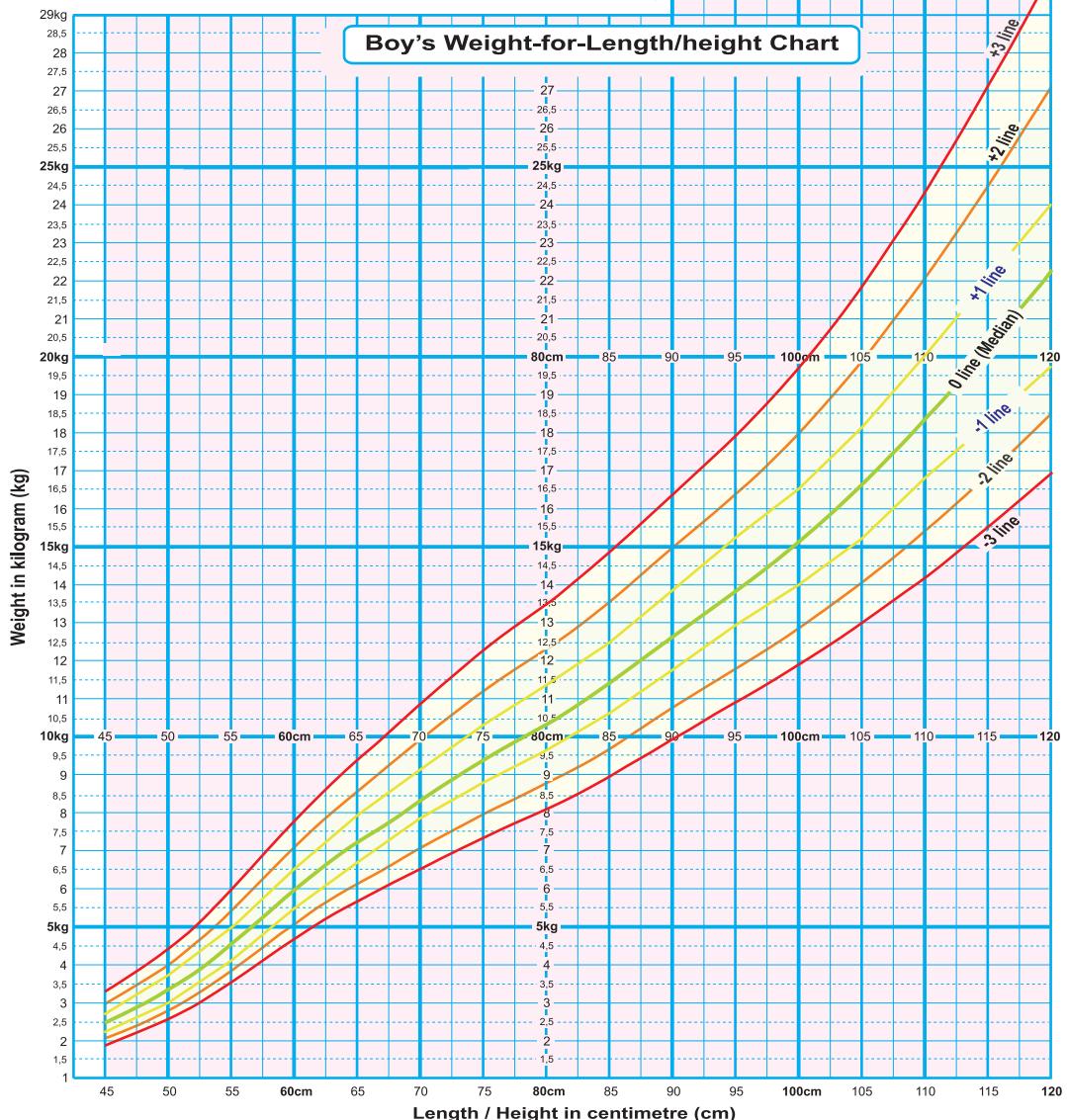
Birth to 5 years (z-scores)



## FOR PERIODIC USE

(every 6 months) Indicate under  
"Growth" (page 2 & 3) if child is stunted

**FOR PERIODIC USE**  
 (every 6 months) Indicate under  
 "Growth" (page 2 & 3) if child is wasted



This Weight-for-Length/height Chart shows body-weight relative to length/height in comparison to the Median (the 0 z-score line).

A boy whose weight-for-length/height is above the +3 line, is **obese**.  
 A boy whose weight-for-length/height is above the +2 line, is **overweight**.

A boy whose weight-for-length/height is below the -2 line, is **wasted**.  
 A boy whose weight-for-length/height is below the -3 line, is **severely wasted**. Refer for urgent specialised care.

| <b>MID-UPPER ARM CIRCUMFERENCE (MUAC) (Every 3 months)</b>   |                  |                              |                              |                     |      |               |      |
|--|------------------|------------------------------|------------------------------|---------------------|------|---------------|------|
| Date of visit  | MUAC             | Date of visit                | MUAC                         | Date of visit       | MUAC | Date of visit | MUAC |
|  |                  |                              |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
| <p>&lt; 11.5 cm indicates severe acute malnutrition (REFER urgently)<br/> <math>\geq 11.5 &lt; 12.5</math> cm indicates moderate acute malnutrition (Manage as in IMCI guidelines)</p> |                  |                              |                              |                     |      |               |      |
| <b>HOSPITAL ADMISSIONS</b>   |                  |                              |                              |                     |      |               |      |
| Hospital name  | Admission number | Date of admission dd/mm/yyyy | Date of discharge dd/mm/yyyy | Discharge diagnosis |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
|  |                  | / /                          | / /                          |                     |      |               |      |
| <b>NAME OF CLINIC(S) VISITED</b>   |                  |                              |                              |                     |      |               |      |
| Clinic 1:  |                  | Clinic 2:                    |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |
| Clinic 3:  |                  | Clinic 4:                    |                              |                     |      |               |      |
|  |                  |                              |                              |                     |      |               |      |

## ORAL HEALTH EXAMINATIONS

**Refer child if scheduled examinations have not been done.  
To be completed by Dentist, Dental Therapist or Oral Hygienist.**

**Schedule of visits:**

1<sup>st</sup> visit on appearance of first tooth

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

At age 12 months, when attending immunizations

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

In the 2<sup>nd</sup> year, with other health checks

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

In the 3<sup>rd</sup> year, with other health checks

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

In the 4<sup>th</sup> year, with other health checks

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

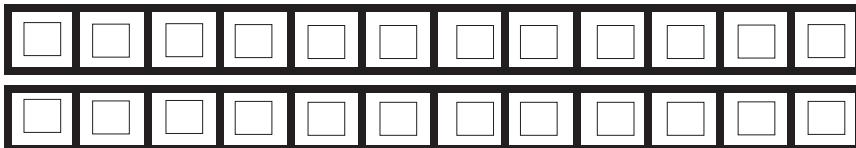
In the 5<sup>th</sup> year, with other health checks

Examiner: \_\_\_\_\_ Health facility: \_\_\_\_\_ Date: \_\_\_\_\_

Use a clean cloth to clean your baby's gums

Use a small soft toothbrush to clean the baby's teeth

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |



|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |





CLINICAL NOTES

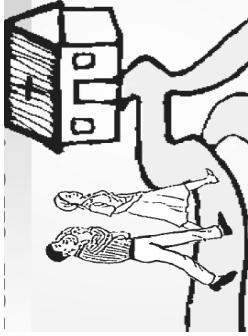
CLINICAL NOTES

CLINICAL NOTES





**Take your child to the nearest clinic when any of the these danger signs occur:**



**Vomiting everything**



**Unable to breastfeed**

**Child lethargic or unconscious**



**Convulsions**



**Diarrhoea with sunken eyes or sunken fontanelle**

**Diarrhoea with blood**



**Chest indrawing**

**Cough and breathing rate more than 50 breaths per minute**



**Child under 2 months and:  
- is not feeding  
- has fever**

