## Handout C: Child Health Record Sample (Part 1)

**CHILD HEALTH RECORD:** **FORM 2A, HEALTH HISTORY**

**TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.**

PERSON INTERVIEWED: JEAN BROWN DATE: 3-1-96 RELATIONSHIP: MOTHER

NAME OF INTERVIEWER: _____ TITLE: _____

| PREGNANCY/BIRTH HISTORY | YES | NO | EXPLAIN "YES" ANSWERS |
|---|---|---|---|
| 1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY? | ✓ | | Hypertension |
| 2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY? | | ✓ | |
| 3. WAS CHILD BORN OUTSIDE OF A HOSPITAL? | | ✓ | |
| 4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE? | | ✓ | |
| 5. WHAT WAS CHILD'S BIRTH WEIGHT? | | | 7 lbs., 2 oz. |
| 6. WAS ANYTHING WRONG WITH CHILD AT BIRTH? | | ✓ | |
| 7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY? | | ✓ | |
| 8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL? | | ✓ | |
| 9. IS MOTHER PREGNANT NOW? | | ✓ | *(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)* |

| HOSPITALIZATIONS AND ILLNESSES | YES | NO | EXPLAIN "YES" ANSWERS |
|---|---|---|---|
| 10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON? | ✓ | | Age 2 yes - asthma |
| 11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)?* | | ✓ | |
| 12. HAS CHILD EVER HAD A SERIOUS ILLNESS? | ✓ | | asthma |

| HEALTH PROBLEMS | YES | NO | EXPLAIN *(Use additional sheets if needed)* |
|---|---|---|---|
| 13. DOES CHILD HAVE FREQUENT ____SORE THROAT; ✓ COUGH; ____URINARY INFECTIONS OR TROUBLE URINATING; ____STOMACH PAIN, VOMITING, DIARRHEA? | ✓ | | Frequent cough in winter |
| 14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)?* | * | ✓ | |
| 15. IS CHILD WEARING *(or supposed to wear)* GLASSES? | | ✓ | *(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____ |
| 16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?* | * ✓ | | ear infections as baby |
| 17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP? | | ✓ | |
| 18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES? | * | ✓ | *If "yes" ask:* WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____ |
| 19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).* | | ✓ | WHAT MEDICINE? _____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? ____ HOW OFTEN? ____ |
| 20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST? | ✓ | | (PHYSICIAN'S NAME: Mary Smith) |
| 21. HAS CHILD HAD: ____BOILS, ✓ CHICKENPOX, ✓ ECZEMA, ____GERMAN MEASLES, ____MEASLES, ____MUMPS, ____SCARLET FEVER, ____WHOOPING COUGH? | | | |
| 22. HAS CHILD HAD: ✓ HIVES, ____POLIO? | * | | When ate peanut butter |
| 23. HAS CHILD HAD: ✓ ASTHMA, ____BLEEDING TENDENCIES ____DIABETES, ____EPILEPSY, ____HEART/BLOOD VESSEL DISEASE, ____LIVER DISEASE, ____RHEUMATIC FEVER, ____SICKLE CELL DISEASE? | * | | *If "yes", transfer information to Forms 1 and 5.* Since age 2 - mostly in winter; some with animals |
| 24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)?* a. WHEN EATING ANY FOODS? ✓ b. WHEN TAKING ANY MEDICATION? _____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____ | * | | *If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? peanuts WHAT MEDICINE? WHAT THINGS? animals HOW DOES CHILD REACT? rash, itch, cough |
| 25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? | ✓ | | DESCRIBE HOW: coughing & colds in winter |
| DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM? | ✓ | | WHEN? Age 2 - asthma |
| 26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERY-DAY ACTIVITIES? | | ✓ | DESCRIBE: |
| DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM? | | | WHEN? |

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*

## Handout C: Child Health Record Sample (Part 1, *continued*)

**CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT**

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

**PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT**

1. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations)*:

Allergy to peanuts / peanut butter

2. SCREENING TESTS. *Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

| TEST | DATE | RESULTS | TEST | DATE | RESULTS |
|---|---|---|---|---|---|
| a. PRESENT AGE* | 3-24-96 | ____Yrs., ____Mos. | g. VISION (Type of Test)* | | SNELLEN |
| b. HEIGHT (no shoes, to nearest 1/8 in.)* | | | ACUITY, R/L | 3-24-96 | 20/25 R, L |
| c. WEIGHT (light clothing to nearest 1/4 lb.:)* | | | RESCREENING | | |
| d. BLOOD PRESSURE | | | STRABISMUS | 11 | NL |
| e. HEMATOCRIT or HEMOGLOBIN* | 3-24-96 | 11.6 | COMMENTS | | |
| f. HEARING (Type of Test)* | | AUDIOMETRY | h. OTHER TESTS (if indicated) | | |
| RESULTS, R/L | 3-24-96 | NL | (1) TB | 3-24-96 | NEG. |
| RESCREENING | | | (2) Sickle Cell | | |
| COMMENTS | | | (3) Lead | 3-24-96 | 12 RECHECK 9/19/96 |
| | | | (4) Ova & Parasites | | |
| | | | (5) Urinalysis | | |
| | | | (6) Other | | |

**PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT**

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start.*

| | NORMAL FOR AGE | ABNORMAL | NOT EVAL. | COMMENTS *(Use Additional sheet if necessary)* |
|---|---|---|---|---|
| a. GENERAL APPEARANCE | ✓ | | | |
| b. POSTURE, GAIT | ✓ | | | |
| c. SPEECH | | | ✓ | NOT ABLE TO ASSESS |
| d. HEAD | ✓ | | | |
| e. SKIN | ✓ | | | |
| f. EYES: (1) External Aspects | ✓ | | | |
| (2) Optic Fundiscopic | ✓ | | | |
| (3) Cover Test | ✓ | | | |
| g. EARS: (1) External & Canals | ✓ | | | |
| (2) Tympanic Membranes | ✓ | | | |
| h. NOSE, MOUTH, PHARYNX | | | | |
| i. TEETH | | ✓ | | UPPER FRONT TEETH DECAYED |
| j. HEART | ✓ | | | |
| k. LUNGS | ✓ | | | |
| l. ABDOMEN (include hernia) | ✓ | | | |
| m. GENITALIA | ✓ | | | |
| n. BONES, JOINTS, MUSCLES | ✓ | | | |
| o. NEUROLOGICAL/SOCIAL | | | | DENVER Devel. Test – Nl. |
| (1) Gross Motor | ✓ | | | |
| (2) Fine Motor | ✓ | | | |
| (3) Communication Skills | ✓ | | | |
| (4) Cognitive | ✓ | | | |
| (5) Self-Help Skills | ✓ | | | |
| (6) Social Skills | ✓ | | | |
| p. GLANDS (Lymphatic/Thyroid) | ✓ | | | |
| q. MUSCULAR COORDINATION | ✓ | | | |
| r. OTHER | | | | |

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature: M. Smith, M.D. Date: 3-24-96

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

| | ABNORMAL FINDINGS/DIAGNOSIS | TREATMENT PLAN | RECOMMENDED FOLLOW-UP OR RESULTS *(Initial when complete)* | DATE |
|---|---|---|---|---|
| a. | DENTAL CARRIES | REF. TO DENTIST | | |
| b. | | | | |
| c. | | | | |
| d. | | | | |

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*

## Handout C: Child Health Record Sample (Part 2)

**CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT**

**PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT**

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations):*

Allergy to peanuts/peanut butter

2. SCREENING TESTS. *Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

| TEST | DATE | RESULTS | TEST | DATE | RESULTS |
|---|---|---|---|---|---|
| | | | g. VISION (Type of Test)* | | SNELLEN |
| | | | ACUITY, R/L | 3-24-96 | 20/25 R, L |
| | | | RESCREENING | | |
| | | | STRABISMUS | 11 | NL |
| | | | COMMENTS | | |
| e. HEMATOCRIT or HEMOGLOBIN* | 3-24-96 | 11.6 | h. OTHER TESTS (if indicated) (1) TB | 3-24-96 | NEG. |
| f. HEARING (Type of Test)* | | AUDIOMETRY | (2) Sickle Cell | | |
| RESULTS, R/L | 3-24-96 | NL | (3) Lead | 3-24-96 | 12 REDRAWN 9/19/96 |
| RESCREENING | | | (4) Ova & Parasites | | |
| COMMENTS | | | (5) Urinalysis | | |
| | | | (6) Other | | |

| Immunizations | Birth to 1 Month | 2 Months | 4 Months | 6 Months | 12-18 Months | 4-6 Years |
|---|---|---|---|---|---|---|
| DTP | | 5-17-92 | 8-28-92 | 11-3-92 | 8-1-93 | 3-24-96 |
| Polio | | 5-17-92 | 8-28-92 | | 8-1-93 | 3-24-96 |
| HIB | | 5-17-92 | 8-28-92 | 11-3-92 | 8-1-93 | |
| Hep B | | | | | | |
| MMR | | | | | 8-1-93 | 3-24-96 |
| Other | | | *Note: Ages and number of boosters may vary when immunizations start at older ages.* | | | |

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*

## Handout C: Child Health Record Sample (Part 3)

**CHILD HEALTH RECORD:** **FORM 2B, HEALTH HISTORY (Continued)**

PERSON INTERVIEWED: JEAN BROWN DATE: 3-1-96 RELATIONSHIP: Mother

NAME OF INTERVIEWER: _____ TITLE: _____

**PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT**

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?
Likes climbing structures at park
Likes dressing up & acting

28. DOES YOUR CHILD TAKE A NAP? ____NO; ✓ YES. IF "YES" DESCRIBE WHEN AND HOW LONG. 1 hr. - pm

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? ✓ NO, ____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? goes by self

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW? a little shy

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE? likes to play

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN? a little shy

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ____NO, ✓ YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID? VERY SAD when parents fighting & split-up

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO ____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO ____?

| | EARLIER | WHEN EXPECTED | LATER | AGE |
|---|---|---|---|---|
| (a) SIT UP WITHOUT HELP | | ✓ | | 5 MO |
| (b) CRAWL | | ✓ | | 7 MO |
| (c) WALK | | ✓ | | 11 MO |
| (d) TALK | ✓ | | | 18 MO |
| (e) FEED AND DRESS SELF | | ✓ | | 1-2 YR |
| (f) LEARN TO USE THE TOILET | | ✓ | | 2 YR |
| (g) RESPOND TO DIRECTIONS | | ✓ | | 1 YR |
| (h) PLAY WITH TOYS | | ✓ | | 1 YR |
| (i) USE CRAYONS | | ✓ | | 2 YR |
| (j) UNDERSTAND WHAT IS SAID TO HIM/HER | ✓ | | | 1 YR |

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? ✓ NO, ____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? ____NO, ✓ YES. IF "YES" PLEASE DESCRIBE. split-up with husband
New baby at home

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? ____NO, ✓ YES. IF "YES" PLEASE DESCRIBE. split-up with husband
finances

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*

## Handout C: Child Health Record Sample (Part 4)

**CHILD HEALTH RECORD:** **FORM 5, DENTAL HEALTH**

(COMPLETE AT INTERVIEW)

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No ✓ Unknown ___ Yes ___
   - Fluoridated water? No ___ Unknown ___ Yes ✓
   - Fluoride Supplement diet? (tablets ___, liquid ___) No ✓ Unknown ___ Yes ___

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?
   Caps

PART I. TO BE COMPLETED BY HEAD START STAFF

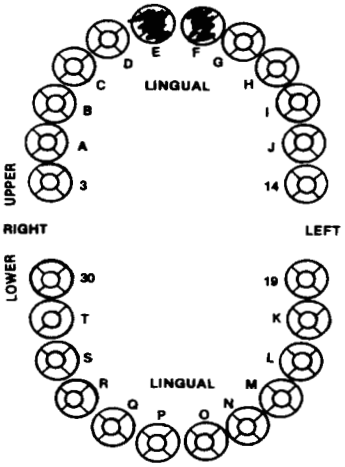
3. CHILD (___HAS, ✓ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name ✓ Date last visit ___
4. CHILD (✓ IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name ✓
5. CHILD (___IS, ✓ IS NOT) RECEIVING MEDICATION.
   Type ___
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Allergies | ✓ | | Liver Dis. | | ✓ |
| Asthma | ✓ | | Rheumatic Fever | | ✓ |
| Bleeding | | ✓ | Sickle Cell Dis. | | ✓ |
| Diabetes | | ✓ | Other (List Below) | | |
| Epilepsy | | ✓ | | | |
| Heart/Vascular Dis. | | ✓ | | | |

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☑ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency ___
   - ☐ Head Start
   - ☐ In-kind Provider ___
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party) ___
8. PRIORITY GROUP
   - ☑ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*




10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

| Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Service Performed MO. | DAY | YR. | A.D.A. Procedure Number | Actual Charges (Fee) |
|---|---|---|---|---|---|---|---|---|
| E | | STAINLESS STEEL CROWN | | 9 | 20 | 96 | | |
| F | | STAINLESS STEEL CROWN | | 9 | 20 | 96 | | |

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☑ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☑ B. CLEANING
   - ☑ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits ___. Approximate cost ___.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment ( ___is, ✓ is not) complete. If not, explain here, as well as items checked.
   ___
   ___
   - ☑ a. Routine recall visits
   - ☑ b. Special home emphasis, oral hygiene
   - ☑ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☑ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.
   Signature ___ Date 9-20-96

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*

## Handout C: Child Health Record Sample (Part 5)

**CHILD HEALTH RECORD:** **FORM 6, NUTRITION**

**CHILD'S NAME:** JANINE BROWN **SEX:** F **BIRTHDATE:** 3-10-92

**PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW**

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE? Hamburgers, fries, juice, soda

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES? green vegetables, milk

| | Yes | No |
|---|---|---|
| 3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS? | | ✓ |
| (a) If "yes", what kind are they? | | |
| (b) Do they contain iron? | | |
| (c) Do they contain fluoride? | | |
| (d) Were they prescribed? | | |
| 4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR (MEDICAL) RELIGIOUS, OR PERSONAL REASONS? Allergy to peanuts | * ✓ | |
| 5. IS YOUR CHILD ON A SPECIAL DIET? | * | ✓ |
| (a) What kind? | | |
| 6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH? | * | ✓ |
| 7. DOES YOUR CHILD TAKE A BOTTLE? Night / NAP | ✓* | |
| 8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD? | * | ✓ |
| 9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING? | * | ✓ |
| 10. DOES YOUR CHILD OFTEN HAVE: | | |
| (a) Diarrhea? | * | ✓ |
| (b) Constipation? | * | |
| 11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS? | * | ✓ |

12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?

Approximate Number of Times a Week *(circle the number(s) nearest to parent's answer)*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| (a) Milk, cheese, yogurt. | 0* | 1* | 2* | 3 | 4 | (5) | 6 | 7 | 7+ |
| (b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter. | 0* | 1* | 2* | 3 | 4 | (5) | 6 | 7 | 7+ |
| (c) Rice, grits, bread, cereal, tortillas. | 0* | 1* | 2* | 3 | 4 | 5 | 6 | 7 | (+) |
| (d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes. | 0* | (1*) | 2 | 3 | 4 | 5 | 6 | 7 | 7+ |
| (e) Oranges, grapefruit, tomatoes (fruit juice). | 0* | 1* | 2* | 3 | 4 | 5 | 6 | 7 | (7+) |
| (f) Other fruits and vegetables. | 0* | 1* | (2) | 3 | 4 | 5 | 6 | 7 | 7+ |
| (g) Oil, butter, margarine, lard. | 0* | 1* | 2 | 3 | 4 | (5) | 6 | 7 | 7+* |
| (h) Cakes, cookies, sodas, fruit drinks, candy. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (7+*) |

*Starred answers may require follow-up. Explain details or give additional comments here.

**PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST**

13. GROWTH

| DATE | AGE | HEIGHT *(no shoes, to nearest 1/8 in.)* | WEIGHT *(light clothing, to nearest 1/4 lb..)* |
|---|---|---|---|
| 2/12/91 | 1 yrs. 11 mo. | 25" (50th) | 24lb. (25th) |
| 4/30/95 | 3 yrs. 1 mo. | 37½" (50th) | 28lb. (15th) |
| 3/24/96 | 4 yrs. 0 mo. | 40" (50th) | 29lb. (5th) |

14. ANEMIA SCREEN

| | DATE | HEMOGLOBIN* | OR HEMATOCRIT * |
|---|---|---|---|
| SCREENING | 3/24/96 | 11.6 | |
| RESCREENING | | | |

**Hgb less than 11 or Hct less than 34 require follow-up*

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

*(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)*

- ☐ Suspect dietary problem or inadequate food intake *(from Questions 2 to 12)*
- ☐ Hgb. less than 11 gm. or Hct. less than 34% *(from Question 14)*
- ☐ Underweight *(weight less than typical, from Growth Chart 1 or 4)*
- ☐ Overweight *(weight greater than typical, from Growth Chart 1 or 4)*
- ☐ Short for Age *(height less than typical, from Growth Chart 2 or 5)*
- ☐ Wt. for Ht. *(greater or less than typical, from Growth Chart 3 or 6)*

COMMENTS *(use additional page if needed)*

Signature_____ Title_____ Date_____

*For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.*