Maternal information

Pregnancy complications

Blood group Anti D given Yes No

Labour Spontaneous Induced – reason

Labour complications

Type of birth Normal Breech Forceps Caesarean Vacuumed extraction

Other details

Neonatal information

Estimated gestation Apgar 1 minute 5 minutes

Abnormalities noted at birth

Problems requiring treatment

Birth weight (kg) Birth length (cm) Birth head circ (cm)

Newborn Hearing Screen completed Not performed

Vitamin K given yes/no - Injection / Oral 1st dose / / 2nd dose / / 3rd dose / /

Hep B immunisation given yes/no Date given / /

Hep B immunoglobin given Date given / /

Postpartum complications

Feeding at discharge breast bottle

Difficulties with feeding

Date of discharge / / Discharge weight (kg) Head circ (cm)

Milestone	Date	Age
Smiles at parents when look Follows objects with eyes Raises head when lying on tummy Turns eyes toward interesting sounds Chuckles, squeals, gurgles or laughs Starts to make speech-like sounds Holds head up when sitting on your knee Rolls over from tummy to back Rolls over from back to tummy Puts things into mouth Plays with toes Sits up without support Reaches out to be picked up Recognises own name Passes things from one hand to the other Is shy with strangers First tooth Waves goodbye Uses thumb and finger to pick things up Tries to pull self up Stands holding on Claps hands Walks with one hand held Understands simple commands Says ‘Ma-ma’ or ‘Da-da’ appropriately First word (other than ‘Ma-ma’ or ‘Da-da’) Walks alone Holds cup and drinks by self Feeds self with spoon Puts two words together Runs Speaks in short sentences Is usually dry during the day Can draw a straight line and circle Dresses self Is usually dry through the night Manages buttons Ties shoe laces		

Family health history and risk factors (for parents)

1 Have any of your baby's close relatives been deaf or had a hearing problem from childhood?

No Yes

2 Did anyone in the family have eye problems in childhood?

No yes

3 Are any of your baby's close relatives blind in one or both eyes?

No yes

4 During pregnancy, did your baby's mother have rubella, cytomegalovirus, toxoplasmosis, herpes, or any other illness with a fever or rash?

No yes

5 At birth, did your baby weigh less than 1500 grams, need to stay in the intensive care unit for more than two days, or need oxygen for 48 hours or longer?

No yes

6 Was your baby born with any physical problems?

No yes

7 Is there a family history of developmental dysplasia of the hips?

No yes

8 Did you have a breech birth?

No yes

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New Born examination: Date: 00/00/2022

Head and fontanelles # Normal # plagiocephaly # bulging # bruised # others

Eyes including red reflex # Normal / # Abnormal

Ears Normal /Abnormal

Mouth and palate Normal /Abnormal

Cardiovascular Heart sound Dual nil Murmur /Murmur Present

Femoral pulses R / L present

Respiratory rate ……/min

Abdomen and umbilicus Normal Hernia present

Anus Normal /Imperforated/Abnormal

Genitalia Normal /Abnormal

Testes fully descended R / L Normal /Not descended /Hernia present/hydrocele present

Musculo-skeletal

Hips Nil Clicks /Click Present

Skin Normal /Rash /Mark present

Reflexes Normal /Abnormal

Does the mother have any concerns about her baby? Yes No

Outcome : Normal Review Refer

Comments……

Infant Screening – Hearing (Infant hearing screen is aims to detect babies with significant hearing loss at an early age.)

Questionary about hearing

Questions for parents

My baby had severe breathing problems at birth Yes | No

My baby had meningitis Yes | No

My baby had jaundice, requiring an exchange transfusion Yes | No

My baby was in intensive care for more than 5 days after birth Yes | No

I have noticed something unusual about my baby's head or neck,

such as an unusually shaped face, or skin tags Yes | No

My baby has Down Syndrome (Trisomy 21)

or another condition associated with hearing loss Yes | No

Screening date: 23/04/2022

Screened by (Print Name)

Outcome (Please circle) RIGHT Pass Refer LEFT Pass / Refer

Refer to Audiologist Yes Reason:

Repeat screen Required Not required

Repeat Screening date

Screened by (Print Name)

Outcome RIGHT Pass / Refer LEFT Pass / Refer

Refer to Audiologist Yes No

Hearing risk factor identified Yes No

When yes is ticked please consult your health professional to arrange an age

appropriate hearing test at 10-12 months (corrected).

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The 1 to 4 week visit

Questions for parents/carers

Have you completed the family health history risk factor questions ? No | Yes

Are you or anybody else concerned about your baby's hearing? Yes | No

Are you concern about your baby's vision? Yes | No

Does your baby exposed to smoking in the home or outside? Yes | No

Do you place you baby on your back for sleeping? Yes/No

Health professional to Check: Normal Review Refer

Feeding

Are you still breast feeding your baby? Yes No

Did you start giving your baby any of the followings?

Vitamins mineral supplements medicine

Plain water sweetened flavoured water fruit juice tea/infusions

Infant formula cow's milk, soy milk, , evaporated milk, condensed milk

Solid OR semi-solid food

Current recommendations are that babies receive only breast milk until about 6 months of age (may receive vitamins, mineral supplements or medicine) and continue breastfeeding (While receiving appropriate complementary foods) until 12 months of age or beyond.

NHMRC Infant Feeding Guidelines: Information for Health Workers (2012).

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Child health check 1 to 4 weeks By Doctor or Nurse

Weight kg Length cm Head circumference cm

Fontanelles Normal Review Refer

Eyes (Observation / corneal light reflections / white pupil) Normal Review Refer

Cardiovascular (doctor only) Normal Review Refer

Umbilicus Normal Review Refer

Femoral pulses Normal Review Refer

Hip test for dislocation Normal Review Refer

Testes fully descended R / L Normal Review Refer

Genitalia Normal Review Refer

Anal region Normal Review Refer

Skin Normal Review Refer

Reflexes Normal Review Refer

Age-appropriate immunisation completed as per schedule? Yes no

Are there any risk factors?

Hearing Yes no

Vision yes no

Hips

Oral Health yes no

Outcome Normal Review Refer

Appropriate health information discussed? Yes No

Comments

The 6 to 8 week visit

For Parents Child development progress – Learn the Signs. Act Early.

Social/emotional

Does your child Calms down when spoken to or picked up ? Yes/No /Not yet

Does your child Looks at your face ? Yes/No/Not yet

Does your child Seems happy to see you when you walk up to her? Yes/No/Not yet

Does your child Smiles when you talk to or smile at her? Yes/No/Not yet

Language/communication

Does your child Makes sounds other than crying? Yes/No

Does your child Reacts to loud sounds? Yes/No

Cognitive (learning, thinking, problem–solving)

Does your child Watches you as you move? Yes/No

Does your child Looks at a toy for several seconds? Yes/No

Movement/physical development

Does your child Holds head up when on tummy? Yes/No

Does your child Moves both arms and both legs? Yes/No

Does your child Opens hands briefly? Yes/No

Others

Have you had my postnatal check? No | Yes

Are concerned about my baby? Yes | No

Have you completed Family health history and risk factors (for parents) No | Yes

Are you concerned about my baby's hearing Yes | No

Does you baby turn towards light ? No | Yes

Does your baby looks at your face and makes eye contact with you ? No | Yes

Have you noticed that one or both of your baby's pupils are white? Yes | No

Do baby and your enjoy being together ? No | Yes

If you circled any answer in RED , pleasetell your doctor or child and family health nurse.

Feeding

Since this time yesterday, did your baby receive breast milk? Yes/no

Since this time yesterday, did your baby receive any of the following?

a) Vitamins OR mineral supplements OR medicine (if required) yes/no

b) Plain water OR sweetened (Misri Water)/flavoured water (Golab Jall) OR fruit juice OR tea/infusions Yes/no

c) Infant formula OR other milk (e.g. cows milk, soy milk, evaporated milk, condensed milk etc) Yes/no

d) Solid OR semi-solid food Yes/no

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Child health check 6 to 8 weeks for Nurse/Doctor

Weight kg % Length cm % Head circumference cm %

Eyes Observation

Corneal light reflection Normal /Abnormal

Fixation Normal /Abnormal

Response to looking with one eye Normal /Abnormal

Eye movements Normal /Abnormal

Cardiovascular (doctor only) Normal /Murmur Present

Hip test for dislocation Normal /Click Present

Testes fully descended R / L Normal /Not descended

Parent questions completed? Yes/no

Age appropriate immunisation completed as per schedule? Yes/no

Are there any risk factors?

Hearing yes/no

Vision yes/no

Hips yes/no

Oral health concern Yes/no

Outcome Normal Review Refer

Comments ……

The 4 months old Questionary:

For Parents :

Do you have any concerns regarding Feeding? Yes No

Since this time yesterday, did your baby receive breast milk? Yes/no

Since this time yesterday, did your baby receive any of the following?

a) Vitamins OR mineral supplements OR medicine (if required) yes/no

b) Plain water OR sweetened (Misri Watrer) /flavoured water(Golab Jaal) OR

fruit juice OR tea/infusions Yes/no

c) Infant formula OR other milk (cows milk, soy milk, evaporated milk, condensed milk etc) Yes/no

d) Solid OR semi-solid food Yes/no

It is recommended that your baby is exclusively breastfed, with no other milks, food or drinks, until about 6 months.

Social/emotional

Does your chid Smiles on his own to get your attention? No /Yes

Does your chid Chuckles (not yet a full laugh) when you try to make her laugh? No /Yes

Does your chid Looks at you, moves, or makes sounds to get or keep your attention? No /Yes

Language/communication

Does your chid Makes sounds like “oooo”, “aahh” (cooing) ? No /Yes

Does your chid Makes sounds back when you talk to him? No /Yes

Does your chid Turns head towards the sound of your voice? No /Yes

Cognitive (learning, problem-solving)

Does your chid If hungry, opens mouth when she sees breast or bottle? No /Yes

Does your chid Looks at his hands with interest? No /Yes

Does your chid Other important things to share with the doctor…? No /Yes

What are some things you and your baby do together? Tell this to your doctor /Nurse

What are some things your baby likes to do? Tell this to your doctor /Nurse

Is there anything your baby does or does not do that concerns you? Yes /No

Has your baby lost any skills he/she once had? Yes/No

Does your baby have any special healthcare needs or was he/she born prematurely? Yes/No

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The 6 months old Visit:

For Parents Child development progress

Social/emotional

Does the child knows familiar faces and begins to know if someone is a stranger? Yes/no /Unsure

Does the child laugh and often seems happy ? yes/no/Unsure

Does the child likes to look at self in a mirror? yes/no/ Unsure

Language/communication

Does the child responds to sounds by making sound ? yes/no /Unsure

Does the child taking turns with parent while making sound? yes/no/ Unsure

Does the child responds to own name? yes/no/ Unsure

Does the child make sounds to show joy and displeasure? yes/no/ Unsure

Does you child make Squealing Noises ? Yes/No /Unsure

Does your child Stick tongue out and blow? Yes/No /Not Sure

Cognitive (learning, problem-solving)

Does the child looks around at things nearby? yes/no/ Unsure

Does the child brings things to mouth to explore them? yes/no/ Unsure

Does the child shows curiosity about things and tries to get things that are? yes/no/ Unsure

Does the child out of reach to grab a toy? yes/no/ Unsure

Does the child close lips to show he/she does not want more food? Yes/No Unsure

Does the child pass things from one hand to the other ? yes/no/ Unsure

Movement/physical development

Does the child rolls over in both directions (front to back, back to front) ? yes/no/ Unsure

Does the child begins to sit without support? yes/no/ Unsure

Does the child when standing, supports weight on legs and might bounce? yes/no/ Unsure

Does the child rocks back and forth, sometimes crawling backward before moving forward. ? yes/no/ Unsure

Additional questions for parents/carers

Are you concerns about your Baby ? Yes | No

I have completed the Family health history and risk factors (for parents) No | Yes

I have completed the dental risk factor questionary in dental section No /Yes

I am concerned about my baby's hearing Yes | No

Others have said they are concerned about my baby's hearing Yes | No

My baby turns toward light No | Yes

I have noticed one or both of my baby's pupils are white Yes | No

My baby and I enjoy being together No | Yes

I read, talk to and play with my baby No | Yes

My baby is exposed to smoking in the home or car Yes | No

I place my baby on their back for sleeping No | Yes

If you answer in red , please tell your doctor or child and family health nurse.

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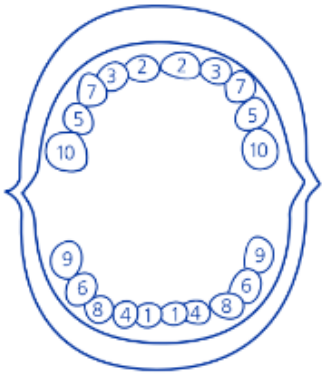
Dental section:

When do babies' teeth come through?

Usual eruption order	Name of tooth	Approximate age at eruption
1,2,3,4	Incisors	6–12 mths
5,6	Baby first molars	12–20+ mths
7,8	Canines	18–24 mths
9,10	Baby second molars	24–30 mths



Teething

• If your child is uncomfortable when teething, offer a teething ring or cold wash cloth.

• If there are other symptoms, consult a doctor or a child and family health nurse.

Food and drink

• Offer healthy food for meals and snacks from around 6 months of age.

• Leave baby foods unsweetened.

• Tap water (boiled then cooled until 12 months of age) is the best drink in-between meals and at bedtime.

• Keep treats, sweet snacks and sweet fizzy drinks for special occasions only.

Toothbrushing tips

• Keep your own teeth and gums clean and healthy. Germs from your mouth can pass over to your baby's mouth on dummies, bottles and spoons.

• As soon as your child's first teeth appear, clean them using a child-sized soft toothbrush, without toothpaste.

• From 18 months of age clean your child's teeth twice a day with a small pea-sized amount of low-fluoride toothpaste. Use a child-sized soft toothbrush; children should spit out, not swallow, and not rinse.

• Toothpaste may be introduced earlier, based on the advice of either a health professional with training in oral health or an oral health professional.

• An adult should apply toothpaste for children under 6 years of age and store toothpaste out of the reach of children.

• From around 3 years of age children can do some of the tooth-brushing themselves, but they still need an adult's help to brush their teeth until they are around 7 to 8 years of age.

• Watch for early signs of tooth decay – white or brown spots that don't brush off. Seek professional advice as soon as possible.

• Make sure your child has an oral health risk assessment conducted by a health professional with training in oral health or an oral health professional by their first birthday.

Dental Risk Factor Questionary:

Do you use a toothbrush and fluoridated toothpaste twice a day? Yes No

Is there a family history of dental disease parent/child and/or sibling)? No Yes

Do you see a dentist regularly? Yes/No

If you circled any answer in the first column, please tell your doctor or Health care Nurse

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5,6	Baby first molars	12–20+ mths
7,8	Canines	18–24 mths
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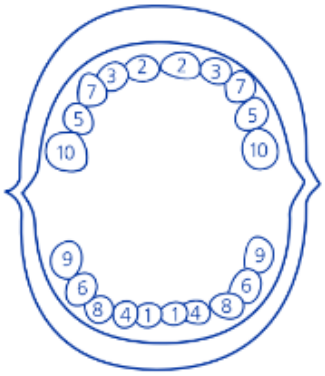

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Child health check 6 months

Assessment by child and family health nurse, GP or paediatrician.

Weight ☐ kg ☐% Length ☐ cm ☐ % Head circumference ☐ cm ☐ %

Eyes Observation

Corneal light reflections Normal / Review / Refer

Fixation Normal / Review / Refer

Response to looking with one eye Normal / Review / Refer

Eye movements Normal / Review / Refer

Oral health (Lift the lip and check)

Visible plaque Normal / Review / Refer

White spot or carious lesions Normal / Review / Refer

Hips: Clinical observation of physical signs Normal / Review / Refer

Testes fully descended Right / Left Normal / Review / Refer

Have the family health history and risk factors been completed? Yes/No

Parent questions completed? Yes/no

Age-appropriate immunisation completed as per schedule? Yes/no

Are there any risk factors?

Hearing Yes/no

Vision Yes/No

Hips Yes/no

Oral Health Yes/No

Outcome Normal Review Refer

Comments …….

The 12 months old Check: for parents/carers

Answer these questions before you visit your nurse or doctor

Social/emotional

Is the Child shy or nervous with strangers? Yes/No /Not sure

Does the child cries when mum or dad leaves ? Yes/No /Not sure

Does the child has favourite things and people? Yes/No /Not sure

Does the child shows fear in some situations? Yes/No /Not sure

Does the child hands you a book when he or she wants to hear a story? Yes/No /Not sure

Does the child repeats sounds or actions to get attention? Yes/No /Not sure

Does the child puts out arm or leg to help with dressing? Yes/No /Not sure

Does the child plays games such as “peek-a-boo” and “pat-a-cake”. ? Yes/No /Not sure

Language/communication

Does the child responds to simple spoken requests? Yes/No /Not sure

Does the child uses simple gestures, like shaking head “no” or waving “bye-bye” ? Yes/No /Not sure

Does the child makes sounds with changes in tone (sounds like speech) ? Yes/No /Not sure

Does the child says “mama” and “dada” and exclamations like “uh-oh!” ? Yes/No /Not sure

Does the child tries to say words you say. ? Yes/No /Not sure

Cognitive (learning, thinking, problem-solving)

Does the child explores things in different ways, like shaking, banging, throwing? Yes/No /Not sure

Does the child finds hidden things easily? Yes/No /Not sure

Does the child looks at the right picture or thing when it’s named? Yes/No /Not sure

Does the child copies gestures? Yes/No /Not sure

Does the child starts to use things correctly. For example, drinks from a cup? Yes/No /Not sure

Does the child brushes hair? Yes/No /Not sure

Does the child bangs two things together? Yes/No /Not sure

Does the child puts things in a container, takes things out of a container? Yes/No /Not sure

Does the child lets things go without help? Yes/No /Not sure

Does the child pokes with index (pointer) finger? Yes/No /Not sure

Does the child follows simple directions like “pick up the toy” ? Yes/No /Not sure

Movement/physical development

Does the child gets to a sitting position without help? Yes/No /Not sure

Does the child pulls up to stand, walks holding on to furniture? yes/no not sure

Does the child may take a few steps without holding on? Yes/No /Not sure

Does the child may stand alone? Yes/No /Not sure

Does the child doesn’t crawl? Yes/No /Not sure

Does the child can’t stand when supported? Yes/No /Not sure

Does the child search for things that he or she sees you hide? Yes/No /Not sure

Does the child say single words like “mama” or “dada? Yes/No /Not sure

Does the child learn gestures like waving or shaking head? Yes/No /Not sure

Does the child point to things? Yes/No /Not sure

Does the child drinks from a cup without a lid , as you hold it ? Yes/No /Not sure

Does the child lose skills he/she once had? Yes/No /Not sure

Does your child picks up between thumb and pointer finger ,like bits of food ? yes/No /Not Sure

Additional questions

I have completed the health risk factor questions No | Yes

I have completed the dental risk factor questions No | Yes

I am concerned about my child’s hearing Yes | No

Others have said they are concerned about my child’s hearing Yes | No

I am concerned about my child’s vision Yes | No

My child has a turned or lazy eye (squint or strabismus) Yes | No

My child has difficulty seeing small objects Yes | No

My child recognises familiar objects and people from a distance No | Yes

My child is exposed to smoking in the home/car Yes | No

My child has teeth No | Yes

My child has had problems with their teeth or teething Yes | No

My child uses a bottle to help them go to sleep Yes | No

My child walks around with a bottle or feeder cup between meals Yes | No

I brush my child's teeth twice a day No | Yes

If you answer in red please tell your doctor or child and family health nurse.

Feeding

Since this time yesterday, did your child receive breast milk? Yes/No

Since this time yesterday, did your child receive solid food? Yes/No

Current recommendations are that babies receive only breast milk until about 6 months of age (may receive vitamins, mineral supplements or medicine) and continue breastfeeding (while receiving appropriate complementary foods) until 12 months of age or beyond.

NHMRC Infant Feeding Guidelines: Information for Health Workers (2012).

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The 12 months health check:

Weight kg % Length cm % Head circumference cm %

Eyes Observation

Corneal light reflections	Normal /Review /Refer
Fixation	Normal /Review /Refer
Response to looking with one eye	Normal /Review /Refer
Eye movements	Normal /Review /Refer
Oral health (Lift the lip and check)	Normal /Review /Refer
Visible plaque	Normal /Review /Refer
Bleeding gums	Normal /Review /Refer
White spot or carious lesions	Normal /Review /Refer

Evaluate gait (if walking) Normal /Review /Refer

Testes fully descended R / L N/A Normal /Review/Refer

Parent questions completed? Yes/No

Age appropriate immunisation completed as per schedule? Yes/No

Are there any risk factors?

Hearing Yes/No

Vision Yes/No

Hips Yes/No

Oral Health

Outcome Normal Review Refer

Comments…….

The 18 month visit for parents/carers

Answer these questions before you visit your nurse or doctor

Social/emotional

Does the child Moves away from you, but looks to make sure you are close by? No/Yes

Does the child Points to show you something interesting? No/Yes

Does the child Puts hands out for you to wash them? No/Yes

Does the child Looks at a few pages in a book with you? No/Yes

Does the child Helps you dress him by pushing arm through sleeve or lifting up foot? No/Yes

Does the child likes to hand things to others as play ? No/Yes

Does the child may have temper tantrums? No/Yes

Does the child may be afraid of strangers ? No/Yes

Does the child shows affection to familiar people? No/Yes

Does the child plays simple pretend, such as feeding a doll? No/Yes

Does the child may cling to caregivers in new situations? No/Yes

Language/communication

Does the child says several single words (besides mama ,dada)? No/Yes

Does the child says and shakes head “no” ? No/Yes

Does the child Follows one-step directions without any gestures, like giving you the toy when you say, “Give it to me.”? No/Yes

Cognitive (learning, problem-solving)

Does the child copies you doing chores, like sweeping with a broom? Yes/No /Not sure

Does the child Plays with toys in a simple way, like pushing a toy car? Yes/no /Not sure

Does the child knows what ordinary things are for; for example, telephone, brush, spoon? No/Yes

Does the child points to get the attention of others? No/Yes

Does the child shows interest in a doll or stuffed animal by pretending to feed? No/Yes

Does the child points to one body part? No/Yes

Does the child can follow one-step verbal commands without any gestures

for example, sits when you say “sit down” ? No/Yes

Movement/physical development

Does the child walks alone without holding onto anyone or anything ? No/Yes

Does the child Climbs on and off a couch or chair without help? No/Yes

Does the child pulls toys while walking? No/Yes

Does the child can help undress herself/himself? No/Yes

Does the child drinks from a cup? No/Yes

Does the child eats with a spoon ? No/Yes

Does the child Scribbles ? Yes/No Not sure

Does the child point to show things to others? No/Yes

Does the child lost Skills he or she had Learned? Yes /No

Additional questions

Have completed the Family health history and risk factors (for parents) No | Yes

Have you completed the dental risk factor questions? No | Yes

Are you concerned about my child’s hearing? Yes | No

Does any others have said they are concerned about my child’s hearing? Yes | No

Are you concerned about my child’s vision ? Yes | No

Does your child have a turned or lazy eye (squint or strabismus)? Yes | No

Does your child have difficulty seeing small objects? Yes | No

Does your child recognises familiar objects and people from a distance No | Yes

Does your child is exposed to smoking in the home/car? Yes | No

Does your child has sweet drinks and snacks throughout the day? Yes | No

Does your child still uses a bottle? Yes | No

If you circled any answer in RED, please tell your doctor or child and family health nurse.

Feeding

Since this time yesterday, did your child receive breast milk? Yes/ No

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The 18 months health check

Assessment by a child and family health nurse, GP or paediatrician.

Weight kg % Height cm %

Evaluate gait Normal /Review /Refer

Eyes Observation Normal /Review /Refer

Corneal light reflections Normal /Review /Refer

Fixation Normal /Review /Refer

Response to looking with one eye Normal /Review /Refer

Eye movements Normal /Review /Refer

Oral health (Lift the lip and check)

Visible plaque Normal /Review /Refer

Bleeding and/or swollen gums Normal /Review /Refer

White spot or carious lesions Normal /Review /Refer

Parent questions completed? Yes/no

Age appropriate immunisation completed as per schedule? ? Yes/no

Are there any risk factors?

Hearing Yes/no

Vision Yes/no

Oral Health yes/no

Outcome Normal Review Refer

Comments…….

The 2year health check: for parents/carers

Answer these questions before you visit your nurse or doctor for the 2 year health check.

Social/emotional

Does the child look at your face to see how to react in a new situation? Yes/No

Does the child notice when others are hurt or upset, like pausing or looking sad when someone is crying? Yes/No

Does the child get excited when with other children? Yes/No

Does the child show defiant behaviour? Yes/No

Does the child play mainly beside other children, but is beginning to include other? Yes/No

Language/communication

Does the child Points to things in a book when you ask, like "Where is the bear?" Yes/No

Does the child knows names of familiar people and body parts? Yes/No

Does the child Says at least two words together, like "More milk."? Yes/No

Does the child follows simple instructions? Yes/No

Does the child repeats words overheard in conversation? Yes/No

Does the child use more gestures than just waving and pointing, like blowing a kiss or nodding yes ? Yes/No

Cognitive (learning, thinking, problem solving)

Does the child Plays with more than one toy at the same time, like putting toy food on a toy plate? Yes/No

Does the child begins to sort shapes and colours? Yes/No

Does the child completes sentences and rhymes in familiar books? Yes/No

Does the child Tries to use switches, knobs, or buttons on a toy? Yes/No

Does the child builds towers of four or more blocks? Yes/No

Does the child Holds something in one hand while using the other hand; for example, holding a container and taking the lid off? Yes/No

Does the child follow two-step instructions such as "Pick up your shoes? Yes/No

Does the child and put them in the cupboard"? Yes/No

Does the child names items in a picture book such as a cat, bird or dog? Yes/ No.

Movement, physical development

Does the child stand on tiptoe? Yes/No

Does the child kick a ball? Yes/No

Does the child begin to run? Yes/No

Does the child Walks (not climbs) up a few stairs with or without help? Yes/No

Does the child can eat with a spoon? Yes/No

Does the child throws ball overhand? Yes/No

Does the child makes or copies straight lines and circles. ? Yes/No

Additional questions

Does the child use two-word phrases (for example, "drink milk") . ? Yes/No

Does the child know what to do with common things, like a brush, phone, fork, spoon. ? Yes/No

Does the child copy actions and words. ? Yes/No

Does the child follow simple instructions. ? Yes/No

Does the child walk steadily. ? Yes/No

Does the child lost the skills he or she once had? Yes/No

Other Questions

Have you completed the health risk factor questions? No | Yes

Have you completed the dental risk factor questions? No | Yes

Are you concerned about my child's hearing? Yes | No

Does Others concerned about my child's hearing? Yes | No

Are you concerned about my child's vision? Yes | No

Does your child have a turned or lazy eye (squint or strabismus)? Yes | No

Does your child has difficulty seeing small objects? Yes | No

Does your child recognises familiar objects and people from a distance? No | Yes

Does your child Has exposed to smoking in the home/car? Yes | No

Does your child has sweet drinks and snacks throughout the day ? Yes | No

Does your child still uses a bottle? Yes | No

If you circled any answer in the Red , please tell your doctor or child and family health nurse.

Feeding

Since this time yesterday, did your child receive breast milk? Yes No

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3 years old (for parents or carer)

Social/emotional

Does your child copies adults and friends? Yes/No

Does your child Notice other children and joins them to play without prompting? Yes/No

Does your child takes turns in games? Yes/No

Does your child show concern for a crying friend? Yes/No

Does your child understands the idea of “mine” and “his” or “hers”? Yes/No

Does your child show a wide range of emotions? Yes/No

Does your child Calms down within 10 minutes after you leave her, like at a childcare drop off? Yes/No

Does your child may get upset with major changes in routine? Yes/No

Does your child dresses and undresses by self? Yes/No

Language/communication

Does your child follow instructions with two or three steps? Yes/No

Does your child Says what action is happening in a picture or book when asked, like “running,” “eating,” or “playing” ? Yes/No

Does your child Asks “who,” “what,” “where,” or “why” questions, like “Where is mommy/daddy?”? Yes/No

Does your child say first name, when asked? Yes/No

Does your child names a friend? Yes/No

Does your child Says what action is happening in a picture or book when asked, like “running,” “eating,” or “playing” ? Yes/No

Does your child Talks well enough for others to understand, most of the time? Yes/No

Cognitive (learning, thinking, problem-solving)

Does your child can work toys with buttons, levers and moving parts? Yes/No

Does your child Avoids touching hot objects, like a stove, when you warn her? Yes/No

Does your child understand what “two” means? Yes/No

Does your child Draws a circle, when you show him how to? Yes/no

Does your child turns book pages one at a time? Yes/No

Does your child builds towers of more than six blocks? Yes/No

Does your child screws and unscrews jar lids or turns door handle? Yes/No

Movement/physical development

Does your child climbs well? Yes/No

Does your child runs easily? Yes/No

Does your child pedals a tricycle (three-wheel bike) ? Yes/No

Does your child walks up and down stairs, one foot on each step? Yes/No

Does your child falls down a lot or has trouble with stairs? Yes/No

Does your child drools or has very unclear speech? Yes/No

Does your child Puts on some clothes by himself, like loose pants or a jacket? Yes/No

Does your child simple puzzles, turning handles) ? Yes/No

Does your child doesn’t speak in sentences? Yes/No

Does your child understand simple instructions? Yes/No

Does your child play pretend or omake-believe? Yes/No

Does your child want to play with other children or with toys? Yes/No

Does your child make eye contact? Yes/No

Does your child lost skills he/she once had. ? Yes/No

Additional questions

Have you completed the health risk factor questions ? No | Yes

Have you completed the dental risk factor questions ? No | Yes

Are you concerned about my child’s hearing ? Yes | No

Does others concerned about your child’s hearing? Yes | No

Are you concerned about my child’s vision ? Yes | No

Does your child has a turned or lazy eye (squint or strabismus)? Yes | No

Does your child has difficulty seeing small objects ? Yes | No

Does your child recognises familiar objects and people from a distance? No | Yes

Does your child has exposed to smoking in the home/car ? Yes | No

Are you concerned about my child's teeth ? Yes | No

Does your child has pain in their mouth ? Yes | No

Does your child has sweet drinks and snacks throughout the day? Yes | No

If you circled any answer in Red please tell your doctor or child and family health nurse.

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The 3 years Child health check: (for Nurse or doctor)

Weight kg % Height cm % Body mass index (BMI)

Eyes Observation Normal /Review /Refer

Corneal light reflections Normal /Review /Refer

Fixation Normal /Review /Refer

Response to looking with one eye Normal /Review /Refer

Eye movements Normal /Review /Refer

Oral health (Lift the lip and check) Normal /Review /Refer

Visible plaque Normal /Review /Refer

Bleeding and/or swollen gums Normal /Review /Refer

White spot or carious lesions Normal /Review /Refer

Facial swelling Normal /Review /Refer

Parent questions completed? Yes/No

Age appropriate immunisation completed as per schedule? Yes/No

Are there any risk factors?

Hearing Yes/No

Vision Yes/no

Oral Health

Outcome Normal Review Refer

Comments…….

4 years old (for parents0)

Social/emotional:

Does your child enjoys doing new things? yes/No

Does your child Ask to go play with children if none are around, like “Can I play with Alex?” yes/no

Does your child Pretends to be something else during play (teacher, superhero, dog)? Yes/no

Does your child Comforts others who are hurt or sad, like hugging a crying friend? Yes /no

Does your child Avoids danger, like not jumping from tall heights at the playground? Yes/No

Does your child Likes to be a “helper”? Yes/No

Does you child Change behaviour based on where she is (place of worship, library, playground)? Yes/No

Language/communication

Does your child say sentences with four or more words ? yes/No

Does your child say some words from a song, story, or nursery rhyme? Yes/no

Does your child Talks about at least one thing that happened during his day, like “I played soccer.”? Yes/No

Does your child Answers simple questions like “What is a coat for?” or “What is a crayon for?”? yes/No

Cognitive (learning, thinking, problem-solving)

Does your child names some colours and some numbers? Yes/no

Does your child understands the idea of counting

Does your child starts to understand time

Does your child remember what comes next in a well known story? Yes /no

Does your child understands the idea of “same” and “different” ? Yes/no

Does your child draws a person with two to four body parts? Yes/no

Does your child use scissor? Yes/no

Does your child starts to copy some capital letters? yes/no

Does your child plays board or card games? yes/no

Movement/physical development

Does your child hops and stands on one foot up to two seconds ? yes/no

Does your child catch a large ball most of the time? Yes/No

Does your child pours, cuts with supervision, and mashes own food.? Yes ?No

Does your child can’t jump in place? Yes/No

Does your child holds crayon or pencil between fingers and thumb (not a fist)? Yes/no

Does your child show no interest in interactive games or make-believe? Yes/no

Does your child ignore other children or doesn’t respond to people outside the family? Yes/no

Does your child resists dressing, sleeping or using the toilet? Yes/no

Does your child follow three-part commands? Yes/no

Does your child doesn’t understand “same” and “different” ? Yes/no

Does your child use “me” and “you” correctly? Yes/no

Does your child speak unclearly? Yes/no

Does your child loses skills he/she once had. ? Yes/no

Additional questions

Have you completed the health risk factor questions ? No | Yes

Have you completed the dental risk factor questions ? No | Yes

Are you concerned about my child’s hearing ? Yes | No

Does others concerned about your child’s hearing? Yes | No

Are you concerned about my child’s vision ? Yes | No

Does your child has a turned or lazy eye (squint or strabismus)? Yes | No

Does your child has difficulty seeing small objects ? Yes | No

Does your child recognises familiar objects and people from a distance? No | Yes

Does your child has exposed to smoking in the home/car ? Yes | No

Are you concerned about my child's teeth ? Yes | No

Does your child has pain in their mouth ? Yes | No

Does your child has sweet drinks and snacks throughout the day? Yes | No

If you circled any answer in Red please tell your doctor or child and family health nurse.

Before school starts (parents/Carer)

Children who attend pre-school and participate in a quality early childhood education program in the year before school are more likely to have the social, cognitive and emotional skills needed to engage with learning when starting kindergarten.

You can do a lot to help prepare your child for kindergarten before their big 'first day'.

• Give your child lots of love and support. Be excited and enthusiastic about starting school.

• Take your child to kindergarten or pre-school orientation day/s so they are familiar with the grounds.

• Explain the basic school rules, such as putting up your hand, asking before going to the toilet, listening quietly when necessary, and doing what the teacher asks.

• Show your child where the toilets are.

• Try on the uniform and shoes before the first day, just to make sure everything fits.

• Visit the school when other children are there so your child can get used to the noise of the playground and the size of the 'big' students.

• Show your child where the after-school care facilities are, if needed.

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The 4 year health check: (for Doctor/Nurse)

Weight kg % Height cm % Body mass index (BMI)

Vision-test monocularly

Results Vision chart * 6m Right eye 6/ Left eye 6/

Vision chart * 3m Right eye 3/ Left eye 3/

Oral health (Lift the lip and check)

Visible plaque Normal /Review /Refer

Bleeding and/or swollen gums Normal /Review /Refer

White spot or carious lesions Normal /Review /Refer

Facial swelling Normal /Review /Refer

Testes fully descended R / L Normal /Review /Refer

Parent questions completed? Yes/No

Age appropriate immunisation completed as per schedule? Yes/No

Are there any risk factors?

Hearing Yes/No

Vision Yes/No

Oral health Yes/No

Outcome Normal Review Refer

Comment……..

For more ideas on spending time with me go to Love, talk, sing, read, play www.lovetalksingreadplay.com.au. A resource provided by Resourcing Parents.

Language adapted for Australian English by NSW Ministry of Health. Original content provided by the U.S. Centers for Disease Control and Prevention's Learn the Signs. Act Early. Program (www.cdc.gov/ActEarly; June 2017).

For more great ideas on how to support my development, download the Bright Tomorrows app https://www.brighttomorrows.org.au/

For more about starting school and what you can do to get ready,

look at the ‘starting school’ pages of the Department of Education

website at https://education.nsw.gov.au/

Adapted from the Raising Children Network www.raisingchildren.net.au and the

NSW Department of Education https://education.nsw.gov.au/