

WELL CHILD EXAM-EARLY CHILDHOOD: 2 Years

DATE

PATIENT NAME				DOB		SEX		PARENT/GUARDIAN NAME			
Allergies						Current Medications					
Prenatal/Family History											
Weight	Percentile	Length/Height	Percentile	HC	Percentile	BMI	Temp.	Pulse	Resp.	BP (if risk)	
	%		%		%						

Interval History:
(Include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

☐ Grains _____ servings per day

☐ Fruit/Vegetables _____ servings per day

☐ Whole Milk _____ servings per day

☐ Meat/Beans _____ servings per day

☐ City water ☐ Well water ☐ Bottled water

WIC ☐ Y ☐ N

Elimination ☐ Normal ☐ Abnormal

Sleep

☐ Normal (8 – 12 hours) ☐ Abnormal

Additional area for comments on page 2

Screening and Procedures:

☐ Oral Health Risk Assessment

☐ Lead level _____ mcg/dl (required for Medicaid)

☐ Subjective Hearing -Parental observation/ concerns

☐ Subjective Vision -Parental observation/ concerns

Autism Screening

☐ Completed

RESULTS: ☐ No Risk ☐ At Risk

Developmental Surveillance

☐ Social-Emotional ☐ Communicative

☐ Cognitive ☐ Physical Development

Psychosocial/Behavioral Assessment

☐ Y ☐ N

Screening for Abuse ☐ Y ☐ N

Screen If At Risk

☐ IPPD _____ (result)

☐ Hct or Hgb _____ (result)

☐ Dyslipidemia _____ (result)

Immunizations:

☐ Immunizations Reviewed, Given & Charted
– if not given, document rationale

☐ Flu ☐ Other _____

☐ Acetaminophen ____ mg. q. 4 hours

Patient Unclothed ☐ Y ☐ N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

☐ Abnormal Findings and Comments
If yes, see additional note area on next page

Results of visit discussed with parent ☐ Y ☐ N

Plan

☐ History/Problem List/Meds Updated

☐ Fluoride Varnish Applied

☐ Referrals

☐ WIC ☐ Early On

☐ Children Special Health Care Needs

☐ Transportation ☐ Dentist

☐ Other _____

☐ Other _____

Anticipatory Guidance/Health Education
(√ if discussed)

Safety

☐ Teach child to wash hands, wipe nose w/tissue

☐ Limit screen time, watch programs together

☐ Appropriate car seat placed in back seat

☐ Pool/tub/water safety

☐ Use bike helmet

☐ Childproof home - (hot liquids/pots, window guards, cleaners, medicines, knives, guns)

☐ Supervise near pets, mowers, streets

☐ Supervise play, ensure playground safety

☐ Parents use of seat belts

Nutrition/physical activity

☐ Eat meals as a family

☐ 3 nutritious meals, 2-3 healthy snacks

☐ Let toddler decide what/how much to eat

☐ Family physical activity

☐ Physical activity in a safe environment

Oral Health

☐ Dental appointment

☐ Brush teeth w/fluoridated toothpaste

Child Development and Behavior

☐ Listen to and respect your child

☐ Reinforce limits, be consistent

☐ Begin toilet training when child is ready

☐ Hug, talk, read, and play together

☐ Model appropriate language

☐ Encourage self-expression, choices

☐ Praise good behavior and accomplishments

☐ Use positive discipline

Family Support and Relationships

☐ Don't expect toddler to share all toys

☐ Help child express emotions

☐ Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

☐ Discuss child care, play groups, preschool, early intervention programs, parenting

Other Anticipatory Guidance Discussed:

Next Well Check: 30 months of age

A standardized developmental and an autism screening tool to be administered – see page 2.
Page 3 required for Foster Care Children.

Provider Signature: _____

Page 2 - WELL CHILD EXAM- EARLY CHILDHOOD: 2 Years – Developmental Screening
A standardized developmental screening tool and an autism screening tool should be administered (Medicaid required and AAP recommended) at the 2 year visit.
Please record findings on this page.

Developmental, Social/Emotional and Behavioral Health Screenings

Always ask parents or guardian if they have concerns about development or behavior. (You must use a standardized developmental instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening and Autism Screening completed: Date_____

Screener Used: ☐ ASQ ☐ ASQSE ☐ PEDS ☐ PEDSDM ☐ Other tool:_____ **Score:** _____

Autism Screener Used: ☐ M-CHAT ☐ PDDST-II **Score:** ☐ Pass ☐ Fail

Referral Needed: ☐ No ☐ Yes **Agency:** _____

Referral Made: ☐ No ☐ Yes **Date of Referral:**_____ **Agency:** _____

Current or Past Mental Health Services Received: ☐ No ☐ Yes (if yes please provide name of provider)

Name of Mental Health Provider:_____

EPSDT Abnormal results:

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc):

Signature of Staff who gave/scored screener if applicable:_____

Provider Signature: _____

Provider Name_____

Please print

THIS PAGE IS REQUIRED FOR FOSTER CARE CHILDREN

PAGE 3 - WELL CHILD EXAM-EARLY CHILDHOOD: 2 Years

DATE	CHILD'S NAME	DOB
Name and phone number of person who accompanied child to appointment: Name: _____ Phone Number: _____		<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Relative Caregiver (specify relationship) _____ <input type="checkbox"/> Caseworker

Physical completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements

☐ **Yes** Please attach completed physical form utilized at this visit

☐ **No** If no, please state reason physical exam was not completed _____

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Screener Used: ☐ ASQ ☐ ASQSE ☐ PEDS ☐ PEDSDM ☐ Other tool: _____ **Score:** _____

Autism Screener Used: ☐ M-CHAT ☐ PDDST-II **Score:** ☐ Pass ☐ Fail

Referral Needed: ☐ No ☐ Yes **Agency:** _____

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Current or Past Mental Health Services Received: ☐ No ☐ Yes (if yes please provide name of provider)

Name of Mental Health Provider: _____

EPSDT Abnormal results:

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc):

Provider Signature: _____

Provider Name _____

Please print

PARENT HANDOUT

Your Child's Health at 24 Months

Milestones

Ways your child is developing between 2 and 2 ½ years of age.

- May not want to do what parent wants; says, "NO" often
- Likes to explore
- Shows feelings and is playful with others
- Jumps in place, kicks a ball
- Uses short 3 – 4 word phrases
- Can point to 6 body parts
- May have fears about unexpected changes
- Begins to play with other children
- Is able to feed and dress self
- Plays "make believe" games with dolls and stuffed animals

For Help or More Information:

Age Specific Safety Information:

Call 1-202-662-0600 or go to <http://www.safekids.org/safety-basics/>

For help finding childcare:

Child Care Licensing Agency, Michigan Department of Consumer & Industry Services, 1-866-685-0006 or online at:

<http://www.michigan.gov/michildcare>

For information about lead screening:

visit the Michigan Bridges 4 Kids lead website at www.bridges4kids.org/lead.html or contact the Childhood Lead Poisoning Prevention Project at (517) 335-8885

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222 or online at

www.mitoxic.org/pcc

If you're concerned about your child's development:

Contact Early On Michigan at 1-800-327-5966 or Project Find at

<http://www.projectfindmichigan.org/> or call 1-800-252-0052

Parenting skills or support:

Call the Parents HELPLine at 1-800-942-4357 or the Family Support Network of Michigan at 1-800-359-3722

Support for families of children with special health care needs:

Children Special Health Care Services, Family phone line at 1-800-359-3722 or www.mdch.state.mi.us/msa/mdch_msa/cshcs.htm

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at www.ndvh.org

Health Tips:

Are your child's shots up to date? Ask your child's doctor or nurse about a flu shot for your child.

Offer your child a variety of healthy foods every day. Limit junk foods. Eat meals together as a family as often as possible. Turn off the TV while eating together.

Brush your child's teeth at least once a day with a pea-sized amount of fluoride toothpaste. Make sure your child gets a dental checkup once a year.

Each child develops in her own way, but you know your child best. If you think she is not developing well, you can get a free screening. Call your child's doctor or nurse if you have questions.

Parenting Tips:

Take your child outside to play and help him enjoy active games like catch, tag, and hide-and-seek. Give your child simple toys to play with, like blocks, crayons and paper, and stuffed animals.

You may want your child to be toilet trained soon, but she may not be ready until about age 3. Your child will show you when she is ready by being dry after sleep and telling you when she wants to use the toilet.

Don't spank or yell at your child. Calmly, give your child something different to do. Use words to tell child when he or she is doing something good. Help children understand how they are feeling by naming the feeling.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

Safety Tips

- Keep cleaning supplies and medicine locked up and out of reach
- Always hold your child's hand while walking near traffic, including in parking lots. Check behind your car before backing up, in case a child is behind it
- If you have guns at home, keep them unloaded and locked up
- Put a life jacket on your child whenever they are near the water or in a boat. Always watch them around the water
- Keep matches and lighters out of reach