

WELL CHILD EXAM-EARLY CHILDHOOD: 12 Months

DATE

| | | | |
|--------------|-----|-----|----------------------|
| PATIENT NAME | DOB | SEX | PARENT/GUARDIAN NAME |
|--------------|-----|-----|----------------------|

| | |
|-----------|---------------------|
| Allergies | Current Medications |
|-----------|---------------------|

Prenatal/Family History

| | | | | | | | | | |
|--------|------------|--------|------------|----|------------|-------|-------|-------|--------------|
| Weight | Percentile | Length | Percentile | HC | Percentile | Temp. | Pulse | Resp. | BP (if risk) |
| | % | | % | | % | | | | |

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

Nutrition

Breast every _____ hours

Formula _____ oz every _____ hours
With iron Y N

Type or brand _____

City water Well 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

Hct or Hgb _____

Lead level _____ mcg/dl (required for Medicaid)

Subjective Hearing -Parental observation/ concerns

Subjective Vision -Parental observation/ concerns

Developmental Surveillance

Social-Emotional Communicative

Cognitive Physical Development

Psychosocial/Behavioral Assessment

Y N

Screening for Abuse Y N

Screen If At Risk

IPPD _____ (result)

Immunizations:

Immunizations Reviewed, Given & Charted
- if not given, document rationale

IPV HepA HepB Hib PCV

DTaP MMR Flu

Varicella or
Chicken Pox Date: _____

MCIR checked/updated

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

Keep Poison Control number handy

Appropriate car seat placed in back seat

Pool/tub/water safety

Use gates, safety locks, window guards

Childproof home - (dangling cords, heaters, stairs, poisons, medicines, outlets, guns, smoke detectors)

Supervise near pets, mowers, driveways, streets

Nutrition

Discuss Weaning, use whole milk

Self Feeding (avoid hard small food)

3 nutritious meals, 2-3 healthy snacks

Don't force child to eat

Oral Health

If using bottle offer only water

Brush toddler's teeth twice a day with a soft toothbrush and water

Schedule first dental exam

Infant Development

Interactive talking, singing, and reading

Daily/Bedtime Routine

Encourage Safe Exploration

Discourage hitting, biting, aggressive behavior

Avoid TV, videos, computers

Family Support and Relationships

Set simple limits (e.g., use distraction)

Praise good behavior

Set examples and use simple words to discipline - don't yell at, hit or shake baby

Special relationships with parents/caregivers

Encourage trusting relationships

Young siblings should not supervise toddler

Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

Hold and cuddle child

Next Well Check: 15 months of age

Developmental Surveillance on Page 2
Page 3 required for Foster Care Children

Provider Signature: _____

**Page 2 - WELL CHILD EXAM-EARLY CHILDHOOD: 12 Months – Developmental Surveillance
(This page may be used if not utilizing a Validated Developmental Screener)**

| | | |
|------|--------------|-----|
| DATE | PATIENT NAME | DOB |
|------|--------------|-----|

Developmental Questions and Observations

Ask the parent to respond to the following statements about the toddler:

Yes No

 Please tell me any concerns about the way your toddler is behaving or developing

- My toddler likes to be with me.
- My toddler is interested in people, places and things.
- My toddler shows different feelings.
- My toddler drinks from a cup.
- My toddler eats a variety of foods.
- My toddler can make sounds.
- My toddler pulls self to standing position.

Ask the parent to respond to the following statements:

Yes No

- I am sad more often than I am happy.
- I have people who help me when I get frustrated with my toddler.
- I am enjoying my time with my toddler.
- I have time for myself, partner and friends.
- I feel safe with my partner.

Provider to follow up as necessary

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

| Toddler Development | | | Parent Development | | |
|---|-----|----|--|-----|----|
| Stands alone 2 seconds or more | Yes | No | Appropriately disciplines toddler | Yes | No |
| Walks with help | Yes | No | | | |
| Says "Dada or Mama" specifically | Yes | No | Positively talks, listens, and responds to toddler | Yes | No |
| Responds to No | Yes | No | | | |
| Precise pincer grasp | Yes | No | Parent is loving toward toddler | Yes | No |
| Indicates wants by pointing or gestures | Yes | No | | | |
| Is able to transition from one activity to another throughout the day | Yes | No | Uses words to tell toddler what is coming next | Yes | No |
| Appears to have a secure, attached relationship with parent | Yes | No | | | |

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

THIS PAGE IS REQUIRED FOR FOSTER CARE CHILDREN
Page 3 - FOSTER CARE WELL CHILD EXAM-EARLY CHILDHOOD: 12 Months

| | | |
|---|--------------|---|
| 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 _____
- _____

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 completed: Date _____

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

Referral Needed: No Yes

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):

Provider Signature: _____

Provider Name _____

Please print

PARENT HANDOUT

Your Child's Health at 12 Months

Milestones

Ways your child is developing between 12 and 15 months of age.

- Speaks more and more words: 3-10 words by 15 months
- Stacks two or three blocks
- Walks well, climbs steps with help
- Follows simple directions
- Is curious and likes to explore people, places, and things
- Protests and says, "NO!"
- Touches, hugs, and kisses

For Help or More Information:

Health and Nutrition program:

Women, Infant, and Children (WIC) Program, call 1-800-26-BIRTH.

For families of children with special health care needs call:

Children Special Health Care Services, MDCH Family phone line at 1-800-359-3722.

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>

Car seat safety:

- Contact the Auto Safety Hotline at 1-888-327-4236. Visit the website: www.safercar.gov/
- To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at www.seatcheck.org

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

Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or www.usa.safekids.org/

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

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222 or online at www.mitoxic.org/pcc or www.spectrum-health.org

For information about childhood immunizations:

Call the National Immunization Program Hotlines at 1 (800) 232-4636 or online at <http://www.cdc.gov/vaccines>

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at <http://www.ndvh.org/>

Health Tips:

Make sure your child gets her immunizations (shots) on time to protect her from many serious diseases. If your child has missed any shots, make an appointment to catch up.

Your child should be eating different kinds of healthy foods. Eating small pieces of soft table food can give your child the nutrition he needs.

Let your child drink from a cup.

Call your child's doctor or nurse before your next visit if you have any questions or concerns about your child's health, growth, or development.

Parenting Tips:

Play, read, and talk with your child every day. Repeat songs and nursery rhymes that she likes.

Name your child's feelings out loud – happy, sad or mad. Use words to tell him what is coming next. Your child can understand more words than he can say.

Calmly, set limits to keep your child safe by giving her something different to do. Praise your child when she does things that you like.

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 (like a crib) 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

Your child should ride in a rear-facing child safety seat in the back seat of the vehicle as long as possible. He should be at least 12 months old AND weigh at least 20 pounds before he is placed in a forward-facing toddler car seat.

As your child learns to walk and climb, make sure your house is safe to explore. Keep the floor clean, lock poisons away, put things that break on a high shelf, and keep gates closed on stairs.

Your child can choke on small objects. Keep small, hard, round objects (coins, small blocks) out of reach. Avoid giving round pieces of food, such as hot dog slices, grapes, or nuts to eat.