CHILD HEALTH RECORD: FORM 1, GENERAL INFORMATION

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

NAME OF INTERVIEWER: _____ TITLE: _____

1. PERSON INTERVIEWED _____
   DATE _____, RELATIONSHIP TO CHILD _____
2. CHILD'S NICKNAME, IF ANY _____
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   _____
   _____ Zip Code _____
   PHONE _____
4. FATHER'S NAME _____
5. MOTHER'S NAME _____
6. GUARDIAN'S NAME _____
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   _____
   PHONE _____, RELATIONSHIP _____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   _____English _____Spanish
   _____Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES NO EPSDT/Medicaid (Latest certification No.):
   _____
   YES NO Federal, State or Local Agency:
   _____
   YES NO In-Kind Provider: _____
   YES NO Other (3rd party): _____
   ID NO.: _____
   YES NO WIC
   YES NO Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    _____
11. DATE OF LAST VISIT TO DENTIST
    _____

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
    (Name, address, and phone no.):
    Physician _____
    _____
    Clinic _____
    _____
    Hospital ER _____
    _____
    Other _____
    _____
    Dentist _____
    _____
13. IN CASE OF EMERGENCY NOTIFY
    (1) _____
    Relationship _____
    Phone _____ or _____
    (2) _____
    Relationship _____
    Phone _____ or _____
    (3) _____
    Relationship _____
    Phone _____ or _____
14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites _____
    - ☐ Allergy, Medication _____
    - ☐ Other _____
      _____

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER				
MOTHER				
BROTHERS & SISTERS *(oldest first)*				
(1)				
(2)				
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

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

INTERVIEWER: GO TO FORM 2A

CHILD HEALTH RECORD: FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:_____

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

PERSON INTERVIEWED:_____ DATE:_____ RELATIONSHIP:_____

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?			
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?			_____lbs., _____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?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)?*			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			

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?			
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)?*	*		
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:_____)
21. HAS CHILD HAD: ____BOILS, ____CHICKENPOX, _____ECZEMA, _____GERMAN MEASLES, _____MEASLES, _____MUMPS, _____SCARLET FEVER, _____WHOOPING COUGH?			
22. HAS CHILD HAD: _____HIVES, _____POLIO?	*		
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.*
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? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
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? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERY-DAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

* *If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

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

PERSON INTERVIEWED:_____ **DATE:** _____ **RELATIONSHIP:** _____

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?

28. DOES YOUR CHILD TAKE A NAP? _____NO, _____YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

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?_____

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?

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

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

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?

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				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

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.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

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.

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

CHILD'S NAME: _____ **SEX:** _____ **BIRTHDATE:** _____

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):*

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*		____Yrs., ____Mos.	g. VISION (Type of Test)*		
b. HEIGHT (no shoes, to nearest 1/8 in.)*			ACUITY, R/L		
c. WEIGHT (light clothing to nearest 1/4 lb.:)*			RESCREENING		
d. BLOOD PRESSURE			STRABISMUS		
e. HEMATOCRIT or HEMOGLOBIN*			COMMENTS		
f. HEARING (Type of Test)*			h. OTHER TESTS (If indicated)		
RESULTS, R/L			(1) TB		
RESCREENING			(2) Sickle Cell		
COMMENTS			(3) Lead		
			(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				
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				
j. HEART				
k. LUNGS				
l. ABDOMEN (include hernia)				
m. GENITALIA				
n. BONES, JOINTS, MUSCLES				
o. NEUROLOGICAL/SOCIAL				
(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: _____ **Date:** _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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

CHILD HEALTH RECORD — FORM 4. IMMUNIZATIONS

TO BE STARTED BY HEAD START STAFF AT PARENT INTERVIEW,
THEN USED BY PHYSICIAN OR CLINIC FOR COMPLETING RECORD FOR HEAD START.

CHILD'S NAME _____ **SEX** _____ **BIRTHDATE** _____

HEAD START CENTER _____ **PHONE** _____

ADDRESS _____
PARENT OR GUARDIAN **ADDRESS**

1. IMMUNIZATIONS

VACCINE	DATE GIVEN DAY/MO/YR	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
D T P			
Td			
DT			
POLIO -OPV			
MMR			
HIB - IF POSSIBLE SPECIFY VACCINE HBOC, PRP-OMP, OR PRP-D			
HB (AT BIRTH)			
HBIG (AT BIRTH)			
OTHER			

2. EXEMPTIONS

If a child cannot or should not receive a particular immunization, write one of the following reasons in the "Doctor or Clinic" column.

(a) HAS HAD DISEASE (attach physician's note). For Rubella only a serologic test is a valid exemption.
(b) ALLERGIC TO _____ (specify allergen and attach physician's note).
(c) PARENT'S WILL NOT CONSENT (Attach parent consent form).

3. CERTIFICATION OF PREVIOUS IMMUNIZATIONS

I hereby attest that I have seen documentation of any immunizations the child received prior to enrollment in Head Start.

Signature _____ Title _____ Date _____

INTERVIEWER: GO TO FORM 5

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

(COMPLETE AT INTERVIEW)

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?

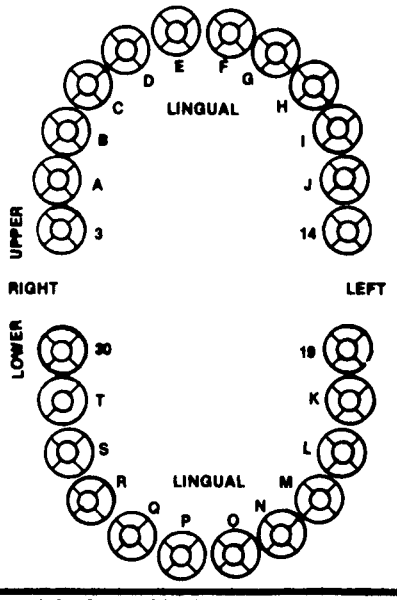
PART I. TO BE COMPLETED BY HEAD START STAFF

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

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)	

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

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_____

INTERVIEWER: GO TO FORM 6

CHILD HEALTH RECORD:

FORM 6, NUTRITION

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

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?_____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	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?	*	
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?	*	
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	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..)*
	____yrs.____mo.		
	____yrs.____mo.		
	____yrs.____mo.		

14. ANEMIA SCREEN

	DATE	HEMOGLOBIN*	OR HEMATOCRIT *
SCREENING			
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_____

GROWTH CHARTS
WITH REFERENCE PERCENTILES
FOR GIRLS
2 TO 18 YEARS OF AGE

Stature for Age
Weight for Age
Weight for Stature

NAME _____ **RECORD #** _____

DATE OF BIRTH _____

Date of Measurement	Age Years	Age Months	Stature	Weight		

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of girls in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of her weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for girls who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

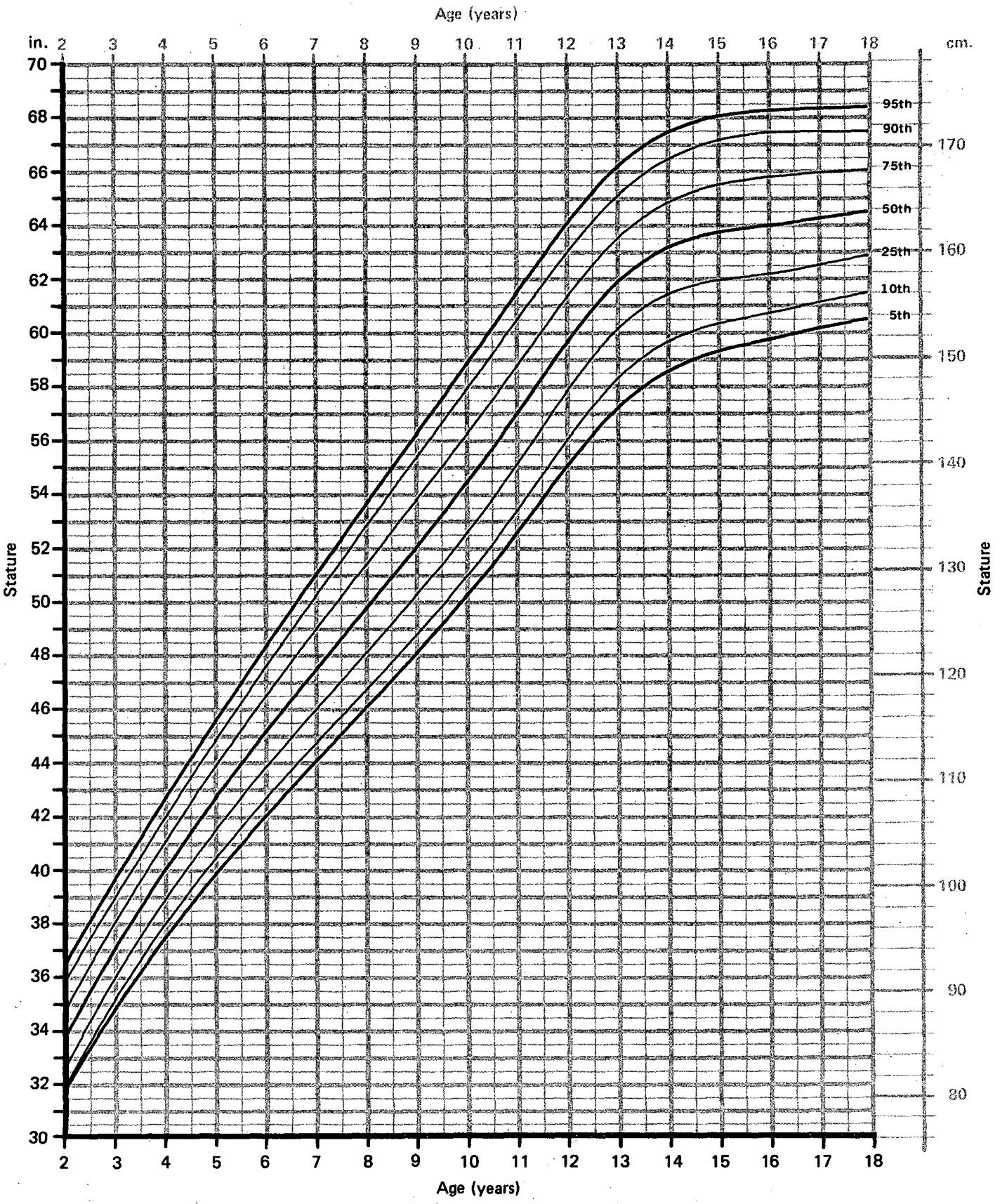
Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If she has changed rapidly in percentile levels, you may want to refer her to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

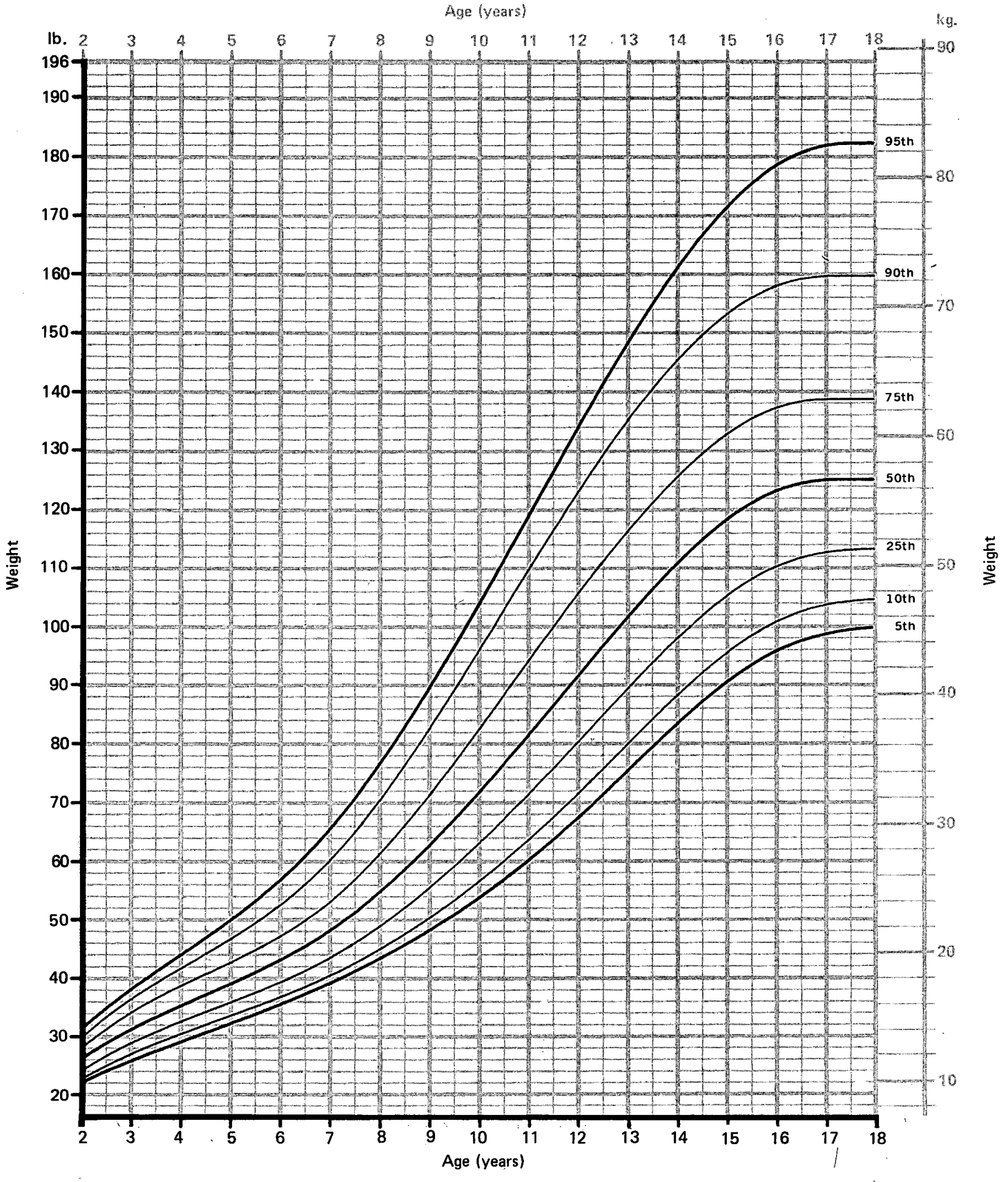
GIRLS FROM 2 TO 18 YEARS

STATURE FOR AGE



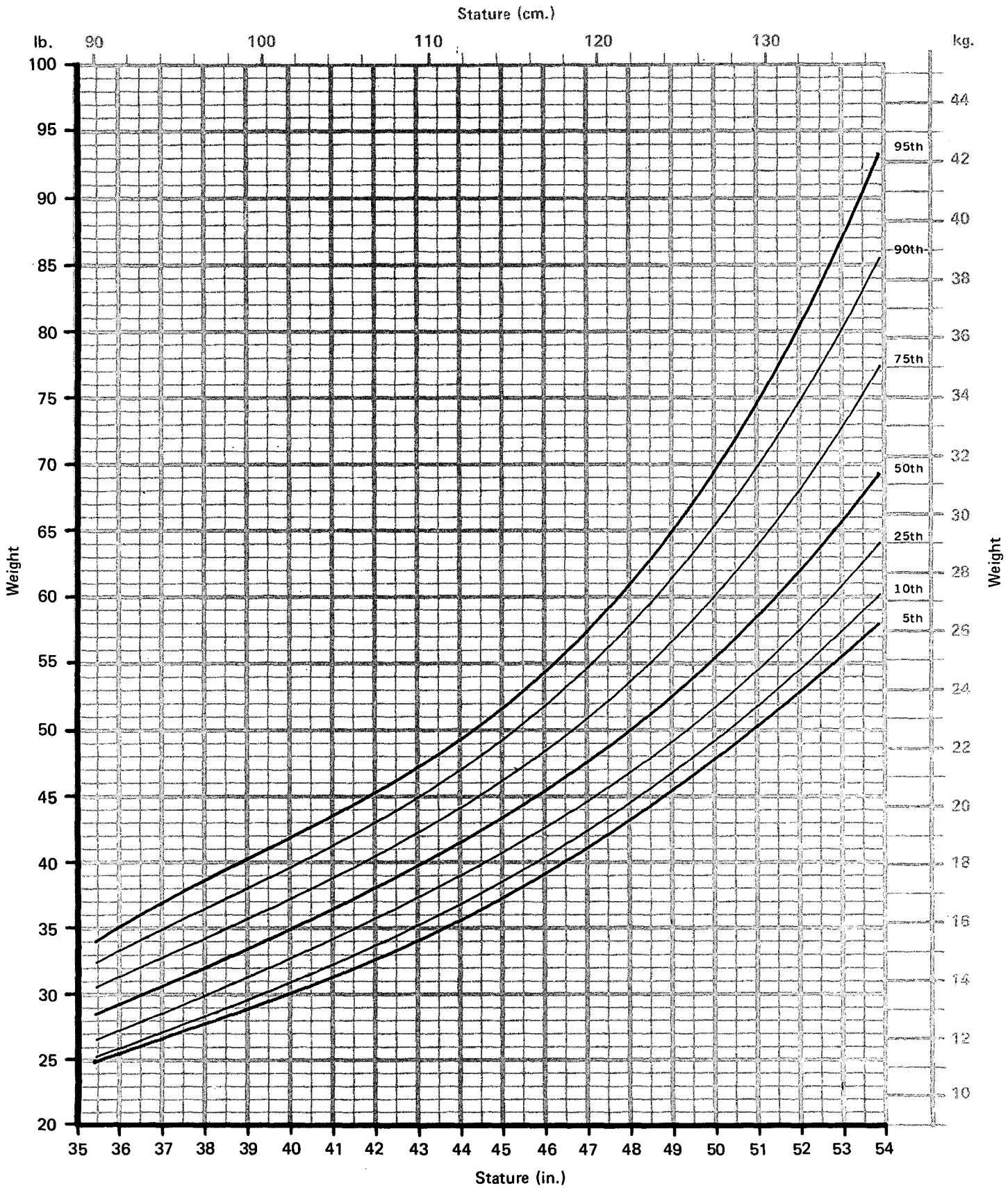
GIRLS FROM 2 TO 18 YEARS

WEIGHT FOR AGE



PRE-PUBERTAL GIRLS FROM 2 TO 10 YEARS

WEIGHT FOR STATURE



GROWTH CHARTS
WITH REFERENCE PERCENTILES
FOR BOYS
2 TO 18 YEARS OF AGE

Stature for Age
Weight for Age
Weight for Stature

NAME _____ **RECORD #** _____

DATE OF BIRTH _____

Date of Measurement	Age Years	Age Months	Stature	Weight		

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of boys in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of his weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for boys who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

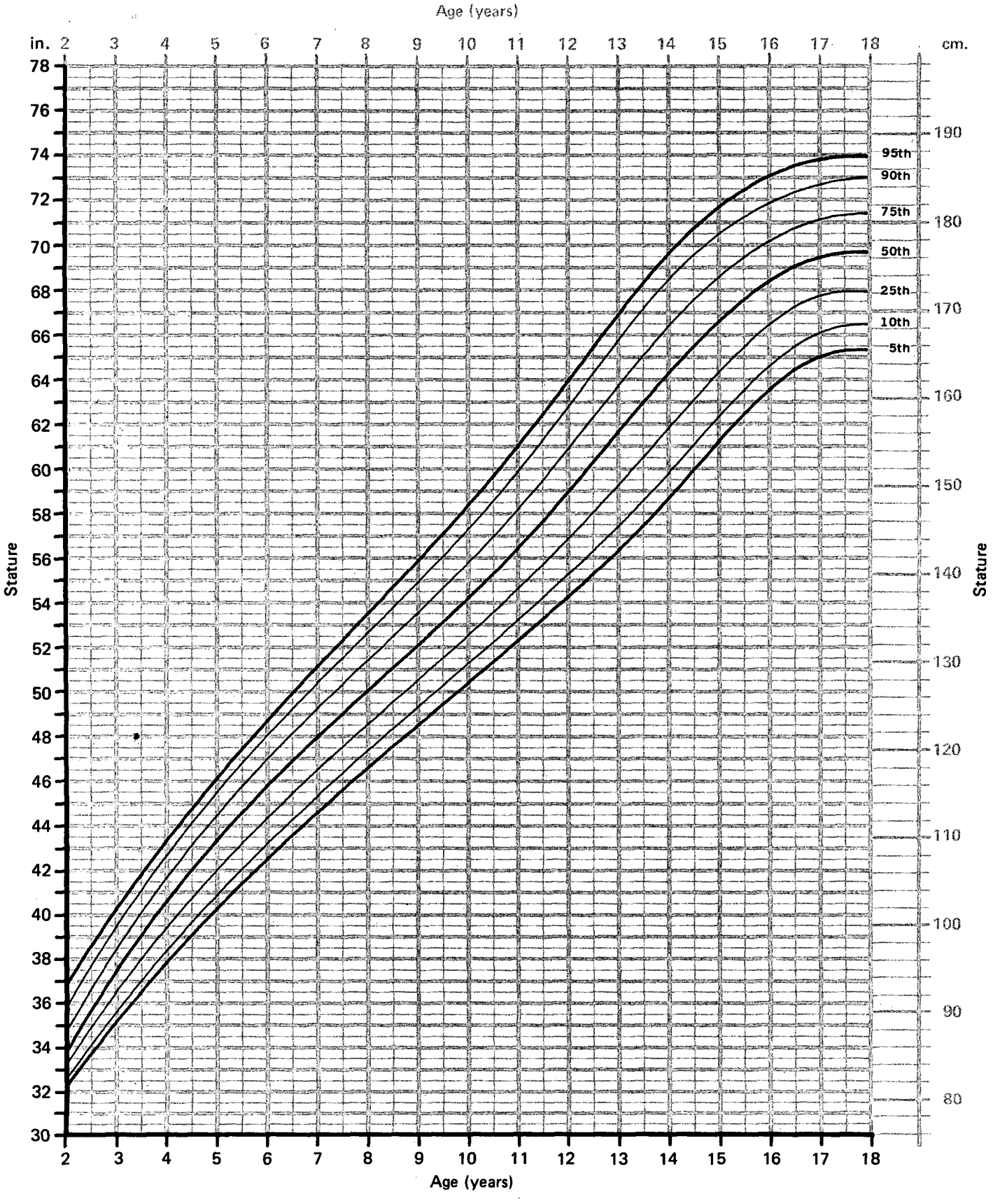
Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If he has changed rapidly in percentile levels, you may want to refer him to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

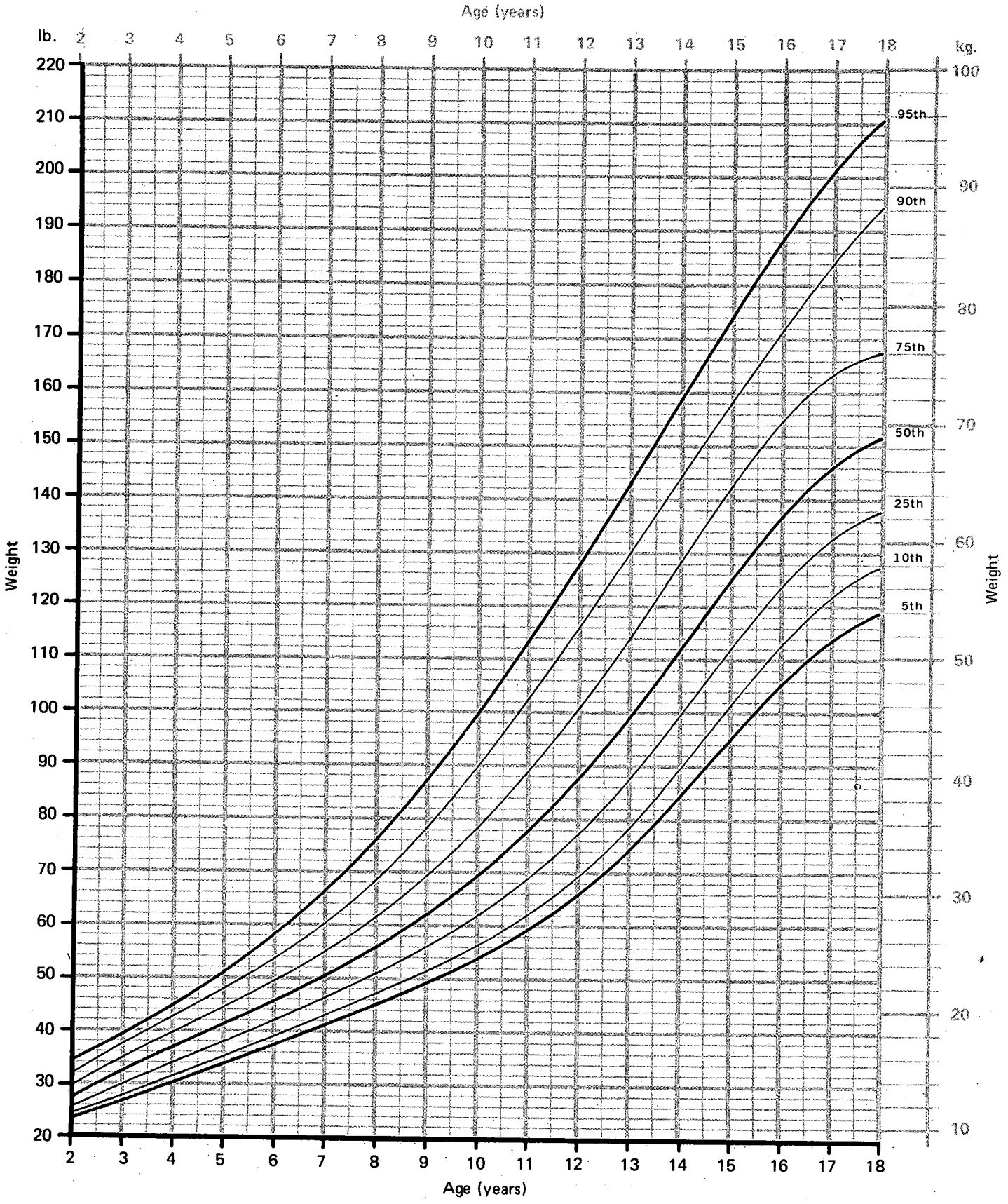
BOYS FROM 2 TO 18 YEARS

STATURE FOR AGE



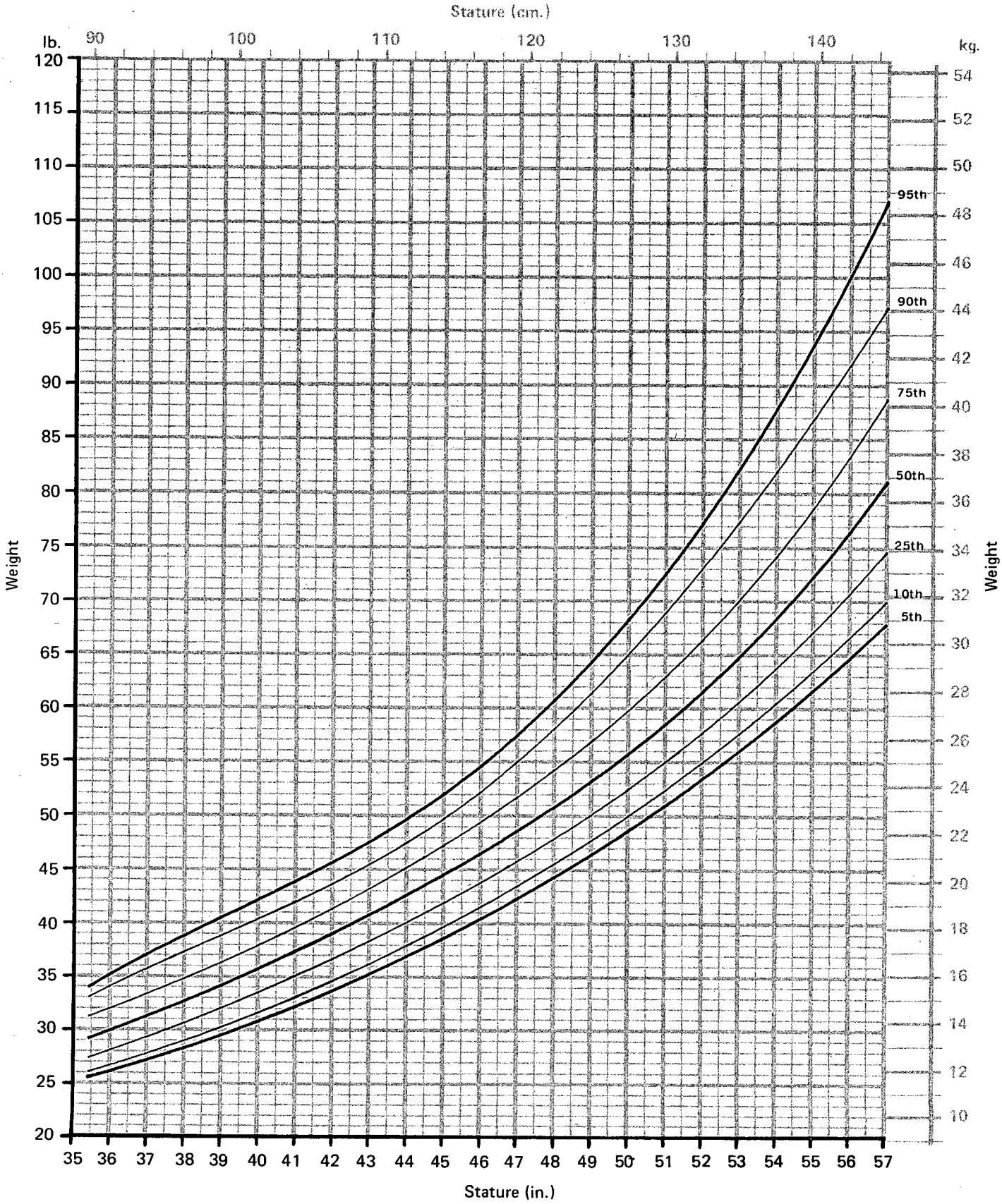
BOYS FROM 2 TO 18 YEARS

WEIGHT FOR AGE



PRE-PUBERTAL BOYS FROM 2 TO 11½ YEARS

WEIGHT FOR STATURE



CHILD HEALTH RECORD: FORM 9, PSYCHOLOGICAL AND SOCIAL DEVELOPMENT

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

PART I. TO BE COMPLETED BY MENTAL HEALTH COORDINATOR OR MENTAL HEALTH PROFESSIONAL

GENERAL STATEMENT *(Strengths, assets, needs or problems identified while the child is enrolled in Head Start. Integrate information from observation, health history, developmental assessment, and other sources):*

PART II. TO BE COMPLETED BY MENTAL HEALTH COORDINATOR

TRACKING RECORD *(Head Start children usually have only one developmental assessment, although children tested before enrollment or retested may have more. If so, use the additional columns.)*

	DEV. ASSESS. No. 1	DEV. ASSESS. No. 2	DEV. ASSESS. No. 3
1. SCREENING METHOD OR INSTRUMENT USED:			
2. STAFF REVIEW OF SCREENING *(Date):*			
3. RESULT OF STAFF REVIEW			
a. No Problem:	☐	☐	☐
b. Reassess:	☐	☐	☐
c. Refer for Developmental Assessment:	☐	☐	☐
4. *(BEFORE REFERRAL)* a. Physical Exam Scheduled *(Date):*			
b. Physical Exam Complete *(Date):*			
c. Results Received			
5. *(IF REFERRED)* a. To *(Name of Professional):*			
b. Appointment Scheduled *(Date):*			
c. Appointment Kept:	☐	☐	☐
d. *(If not)* Appt. Rescheduled:			
e. Report Received *(Date):*			
6. INDIVIDUALIZED PLAN FOR FOLLOW-THROUGH WRITTEN *(Date):*			

CHILD HEALTH RECORD: FORM 10, STAFF OBSERVATIONS OF HEALTH AND BEHAVIOR

TO BE COMPLETED BY TEACHER OR HOME VISITOR EARLY IN PROGRAM YEAR AND UPDATED AS CHANGES OCCUR.

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

OBSERVATIONS	DESCRIBE WHAT YOU HAVE SEEN	DATE (INITIALS)
1. GENERAL CONDITION *(eating habits, nutrition, hygiene, skin condition, posture, undue fatigue):*		
2. GENERAL BEHAVIOR *(alert, responsive, attentive, restless, fearful, shy, aggressive, happy, cooperative, obedient):*		
3. BEHAVIOR AT PLAY *(socially active, solitary, interested, coordinated, excitable, tires easily):*		
4. PERFORMANCE *(memory, achievement, interest, reasoning, pride in performance, attitude, ability to concentrate):*		
5. PERCEPTUAL STATUS *(vision, hearing, speech, understanding, concentration):*		
6. OTHER FACTORS NOTED *(for example, recurring diseases, frequent absences, etc.):*		

7. WHAT IS YOUR OPINION OF THIS CHILD'S HEALTH? *(Use pencil; update as changes occur)*

☐ APPEARS HEALTHY ☐ NOT IN GOOD HEALTH ☐ NOTICEABLE BEHAVIOR PROBLEMS ☐ SPECIFIC PROBLEMS AS NOTED, BUT GENERALLY HEALTHY

Teacher's Signature:_____ Date(s):_____/_____/_____/_____

8. COMMENTS

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