Symptoms Illness/Injury		Date of referral	To Whom Referre	Man (incl.	agement medicine)	Date treated	Health Facility	Health Care Provider's Signature
			1					
			+					
			+			+		
			+			-	-	
			+					
			1					
	-		1		NTMENTS			
Schedule	Da	te ✓ X	New Date	Health Work- er's Signature	Schedule	Date	X New Date	Health Worker Signature
0-10 days					15 months			
3 weeks					18 months			
6 weeks					21 months			
2 months					24 months			
3 months 4 months					30 months 36 months			
5 months			-		42 months			
6months			+		48 months			
omonus								
9 months					54 months	l l	l l	1

 $[\]checkmark$ kept appointment \times did not keep appointment

Produced by the Ministry of Health and the Environment, St. Vincent and the Grenadines, January 2010.

SAINT VINCENT AND THE GRENADINES



CHILD HEALTH - TAKE HOME RECORD

Name of Child:

	GENDER	Re	g. No.	
			,	
ВОҮ		ate Of Birth		
ВОТ	DD	ww	уууу	
1				

KEEP THIS RECORD CLEAN AND IN A SAFE

This is a permanent record of your child's health, growth and development.

Take this record with you whenever and wherever you take your child to clinic, hospital, doctor or other health care provider.

Keep appointments and follow the health team's advice.

This record contains recommendations for feeding and caring for your child at different ages.

This record is required for entry into daycare, preschool, primary and other schools.

				ONAL INFORMA					
Child's First n	2:			Health Centre: Registration No.: Phone No:					
Father's name	:			P	hone No:				
Address: Guardian' s na Address:	me:			P	hone No:				
Child lives with Doctor:	n:				Phone No:		_		
	УО	UR CHILD	'S BIR	TH INFORMAT	ION				
Place of Delivery Home: Hospital:	Birth Order		Is C Twi ther	n Triplet	Pre tem Full tem Post term	APGAR S 1 st Min.	5 th Min.		
Neonatal Screening	her? Delivery Normal C-Section Breech Forceps Other:	Weight Lengtr Head Chest Abdon Birth I Birth I	cit Circumfer Circumfer Circumfe ninal Girth Defects:	kilograms cm ence cm e	Date breast feedinitiated: Time after birth binitiated:h If yes, specify: If yes, specify:	(DD/MM/			
	YOU!			LY HEALTH HIS		LV	N-		
Asthma	ith Condition	Yes	No.	Fits, convulsions, epile	Condition	Yes	No		
Allergy, specify:				Heart disease in any f	•				
Allergy, specify:		_		than 50 years	umily member less				
Early deafness un	der 5 years			Rheumatic fever					
Early eye problem				Emotional/ Mental dis					
Sibling death under Specify cause of	er 5 years, death:			Other family health pr Specify:	oblems:				
		-							

	VISIT NOTES: YOUR CHILD'S GROWTH AND EATING PATTERN									
Date of Visit	Age at visit	Head Size (cm)	Height (cm)	Weight (kg)	Observations	Recommendations				

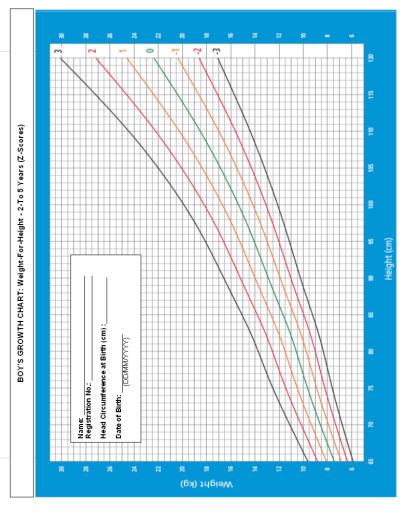
[✓] Record age in completed months from birth to 12 months. If the child is more than 1 year old record age in completed years and months.

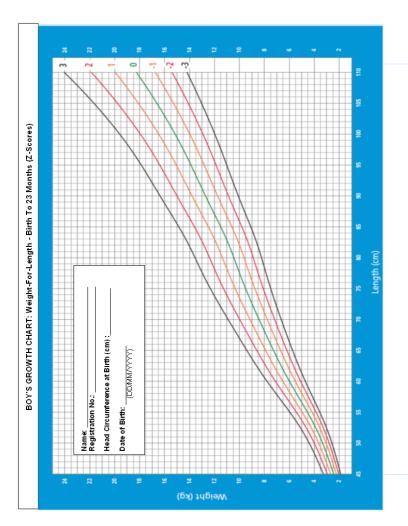
		VI	SIT N	OTES:	YOUR (CHILD'S GROWTH AND EAT	ING PATTERN			
	emoglob		/dl) 5 years	Your child's age when first introduced to semi-solid family tood: n (Age 6+ months is a good time to start)						
6+ to 23 mon	ths	2 10	o years	Your chi	_	hen breastfeeding was ended:	years months			
Date of Visit	Age visi	at t	Head Size (cm)	Length (cm)	Weight (kg)	Observations	Recommendations			
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[✓] Record age in completed months from birth to 12 months. If the child is more than 1 year old record age in completed years and months.

2 Months DPT/Hep B/ Hib DPT/Hep B/ H	National Immunization Schedule (EPI)	Type of Vaccine	Date of Immunization	Country Of Make	Batch #	Signature of Health Work- er	Comments
2 months 8 Weeks/ 2 Months DPT/Hep B/ Hib DPT/Hep B		BCG					
8 Weeks/ 2 Months DPT/Hep B/ Hib DPT/Hep B/Hib DPT							
2 Months DPT/Hep B/ Hib DPT/Hep B/ H	2 months						
1º¹ Dose		OPV or IPV					
18 Weeks/ 4 Months DPT/Hep B/ Hib Dose 24 Weeks/ 6 Months DPT/Hep B/ Hib DPT/Hep	Months						
16 Weeks/ 4 Months DPT/Hep B/ Hib DP	st Dose	Hib					
DPT/Hep B/ Hib DPT	Dose						
DPT/Hep B/ Hib DPT	O Market	ODV or IDV					
Prince P							
24 Weeks							
DPT/Hep B/ Hib DPT/	nd Dose						
DPT/Hep B/ Hib DPT/							
12 Months / 1 Year		OPV or IPV					
12 Months / 1 Year	Months						
12 Months / 1 Year	rd Doos	Hib					
1 Year	Dose						
1 Year							
18 months		MMR					
18 months			BOOSTER	DOSES			
1 year and 6 months 1 Booster 54 To 60 Months 4 ½ - 5 Years DT MMR 10-14 Years And Over The Booster The Company of the Com	8 months /	OPV or IPV					
## Booster 54 To 60 Months	year and 6						
Section Sect							
At ½ – 5 Years DT MMR MMR 10-14 Years And Over 3 rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = inactivated Polio Vaccine; DPT7/HepSi/Hio = Pentavalent Vaccine	- Booster						
MMR 10-14 Years And Over 31" Booster TD (ADULT) Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT/HepBi-Hio = Pentavalent Vaccine	4 To 60 Months	OPV or IPV					
TD (ADULT) And Over To Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT/HepB/Hib = Pentavalent Vaccine							
TD (ADULT) And Over To Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT/HepB/Hib = Pentavalent Vaccine	and managed	MMD					
And Over 3rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/HepBi-Hib = Pentavalent Vaccine	.™ Booster	IVIIVIIX					
And Over 3rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/HepBi-Hib = Pentavalent Vaccine							
And Over 3rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/HepBi-Hib = Pentavalent Vaccine						 	
And Over 3rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/HepBi-Hib = Pentavalent Vaccine							
And Over 3rd Booster Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/Hep5/Hib = Pentavalent Vaccine		TD (ADULT)					
Other Vaccines BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT7/Hep5/Hib = Pentavalent Vaccine							
Key BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT/Hep5/Hib = Pentavalent Vaccine	™ Booster						
Key BCG = Bacile Calmette Guerin; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; DPT/Hep5/Hib = Pentavalent Vaccine	Other Vaccines					-	
DPT/HepB/Hib = Pentavalent Vaccine	Julet Vaccines					-	
DPT/HepB/Hib = Pentavalent Vaccine						 	
DPT/HepB/Hib = Pentavalent Vaccine						 	
DPT/HepB/Hib = Pentavalent Vaccine	(ev	BCG = Bacile	Calmette Guerin: OPV = O	ral Polio Vac	cine: IPV =	Inactivated Polic V	accine.
	,			. a. 7 Ollo Vaci	, 7 -		
DPT= Diptheria, Pertusis, Tetanus Toxoid; Hep B= Hepatitis Type B; Hib= Haemophilus Influe		DPT= Dipther	ia, Pertusis, Tetanus Toxoid	: Hep B= Her	oatitis Type	B; Hib= Haemoph	ilus Influenza

YOUR CHILD'S DEVELOPMENT											
e Gross Motor hs)					Hearing & Sp	eech	Age done	Social Behaviour	& Play	Age done	
Kicks legs when lying on back	0[]	Opens hands	0[]		Makes sounds other than crying	0[]		Smiles in response	0[]		
Raises head up when lying face down	0[]	Follows objects side to side with gaze	0[]		Reacts to sound 8" (20 cm) away at earlevel	0[]		Gazes at your face when lying face up	0[]		
Holds head up when held in a sitting position	0[]	Holds objects briefly	0[]		Coos, gurgles and squeals	0[]		Responds to your smile and talk	0[]		
Rolls over when lying face up	0[]	Reaches out to grasp objects	0[]		Turns head towards sounds on both sides	0[]		Brings object to own mouth	0[]		
Sits without support	0[]	Transfers object from hand to hand	0[]		Makes two syllable sounds (like mama, dada etc.)	0[]		Plays peek-a-boo	0[]		
Walks with support (cruising)	0[]	Picks up small objects between thumb and forefinger	0[]		Babbles	0[]		Imitates gestures (e.g. Waves 'bye bye')	H[]		
Walks without support	H[]	Places objects in a cup	H[]		Speaks one word (other than mama, dada)	H[]		Makes gestures on request	H[]		
Steps backwards	H[]	Scribbles Spontaneous- ly	H[]		Speaks three words (other than mama, dada)	H[]		Identifies two objects on request	H[]		
Climbs onto chairs	H[]	Points to eyes, nose and mouth	H[]					Drinks well from a regular cup, tries to feed self with spoon			
Kicks ball	H[]	Builds a three block tower	H[]		Speaks 2 or 3 word phrase	H[]		Points to two images	H[]		
Runs	H[]				Says own name	H[]			H[]		
Jumps with both feet off the ground	H[]	Points at and names 6 body parts	H[]		Names a friend	H[]		Dresses self but cannot do buttons	H[]		
		Toilet Trained	H[]					Washes and dries hands	0[] H[]		
Stands on one foot and balances self	H[]	Buttons and unbuttons clothing	H[]		Counts up to 10	H[]		Correctly answers the question "Are you a boy or a girl?"	H[]		
	Kicks legs when lying on back Raises head up when lying see down Holds head up when lying see down Holds head up when held in a sitting position Rolls over when lying face up Walks without support Walks without support (cruising) Walks without support (cruising) Kicks ball Runs Jumps with both feet off the ground	Claims without O[]	Cicks legs when O 1				Clock legs when O Opens hands Opens hands		Cicks kegs when O[] Opens hands O[] Makes sounds Of] Smiles in other fram Of] Opens hands O[] Opens hands Opens hands O[] Opens hands Opens hands O[] Opens hands Op	Cicks lags when	





YOUR CHI	ILD'S DENTAL HEALTH						
Child's age at first visit to the dentist:years an	d months. (Age 24 months is a good time to start)						
REASON FOR REFERRAL: (Tick)	easons for referral where applicable)						
Dental Conditions Occurrences							
Delayed Eruption Age (9 months old and older)							
Premature Eruption (before 4 months old)							
Premature Loss Of Teeth (before 4 years old)							
☐ Cleft Lip							
☐ Cleft Palate							
Early Childhood Tooth Decay							
Severe Gum Bleeding or Swelling							

Conditions in the bold in the above table require immediate reterral to a dental surgeon

	F	EEDING GUID	ELINES FOR YOU	JR CHILD	
Age of Child	0 to 6 months (180 days)	6+ to 8 months	9 to 11 months	12 to 23 months	24 months to 5 years
Frequency of Feeds/Meals	Day angle:		If needed add:	If needed add:	DOD
	8 or more feeds in 24 hours	2 to 3 meals daily	3 to 4 meals daily 1 to 2 snacks, if needed	3 to 4 meals daily 1 to 2 snacks, if needed	3 to 4 meals daily 1 to 2 snacks, if needed
Type of foods	BREAST MILK ONLY	Breastmilk + Thick porridge Family foods well mashed	Breastmilk + Family Foods mashed or finely chopped Foods baby can pick up	Breastmilk + Family Foods mashed or chopped Foods baby can pick up	Breastmilk + Family Foods chopped or cooked soft
Amount of foods to offer at each meal	Until baby comes off the breast	2-3 tablespoons Increasing gradually to 4 cup	½ cup	3/4 - 1 cup	1 cup or more Depending on age and activity level

- If the child is not breastfed, ask the health worker for advice on feeding him or her.
- If the child is sick continue feeding and give more fluids (breastfeed more often)
- After illness encourage the child to eat more.

