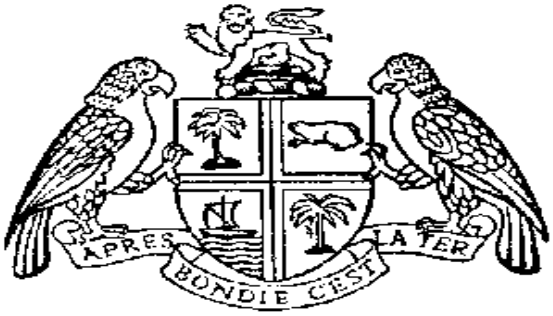
Child Health Record



DOMINICA

MINISTRY OF HEALTH

Boys

Name:

PLEASE KEEP THIS RECORD IN A SAFE PLACE

Please Note:

- **This is a Permanent Record of your Child's Health Status and Immunization. Take it with you whenever and wherever you attend a Clinic or Hospital or visit your doctor.**

- **The booklet is required for entry into institutions of learning- pre-primary, primary and high school , college/university and also as a Visa requirement for certain countries**

Table of Contents

General Information

Child's name _____ Identification Number_____

Date of birth (dd/mm/yy) _____Place of birth _____

Parents'/Guardian's name_____

Address_____

(M)
Emergency Contact (Name)_____ Phone (H)_____

Health Clinic (Name)_____ Phone _____

Private Physician (Name) _____ Phone _____

HEALTH INFORMATION: PERINATAL/ANTENATAL SCREENING

A. **MOTHER**
Complications During Pregnancy:

_____

B. BABY
GESTATION _____ Delivery Method: Normal ☐ Vacuum ☐ Forceps ☐

Caesarean Section ☐ Blood Group: _____ Sickling: _____ Other ☐

Weight _____ Length _____ Head size _____

Condition of Child at Birth: Normal ☐ Resuscitation ☐ NNU ☐

Resuscitative measures: _____

Apgar score: At 1 minute: _____ At 5 minutes _____

Reasons for
admission_____

ALLERGIES (mark in red) _____

Other remarks (Major problems or significant events)

Relevant Family Information

Medical History

Medical Condition	No	Mother	Father	Sibling	Grand parents	Aunt	Uncle
Diabetes							
Hypertension							
Sickle Cell Disease							
Cancer							
Heart Disease							
Seizure Disorder							
Tuberculosis							
Asthma							
Mental Illness							

DEVELOPMENTAL SCREENING CHECK LIST

TICK IN BOX IF MILESTONE HAS BEEN ACHIEVED. ANY ABNORMALITIES DETECTED SHOULD BE REFERRED TO A MEDICAL PRACTITIONER/ PEDIATRICIAN/ PUBLIC HEALTH NURSE.

Age (months)	Gross Motor		Age done	Fine Motor & Vision		Age done	Hearing & Speech		Age done	Social Behaviour & Play		Age done
Under 2 months	Kicks legs when lying on back	O [ ] *		Opens hands	O [ ] *		Makes sounds other than crying	O [ ] *		Smiles in response	O [ ] *	
2 months	Raises head up when lying face down	O [ ] *		Follows objects side to side with gaze	O [ ] *		Child turns reacts to sound 6" away at ear level	O [ ] *		Gazes at your face when lying face up	O [ ] *	
4 months	Holds head up briefly when held in a sitting position	O [ ] *		Holds objects briefly	O [ ] *		Coos, gurgles and squeals	O [ ] *		Responds to your smile and talk	O [ ] *	
6 months	Rolls over when lying face up Bears weight on feet when hand under arm	O [ ] O [ ] *		Reaches out to grasp objects Put in mouth	O [ ] O [ ] *		Child turns head towards sounds on both sides	O [ ] *		Brings object to own mouth	O [ ] *	
9 months	Sits without support	O [ ] *		Transfers object from hand to hand	O [ ] *		Makes two syllable sounds (like mama, dada etc.)	O [ ] *		Finger feeds self	O [ ] *	
	Crawls on hands and knees	O [ ] *										
12 months	Stands alone	O [ ] *		Points with index finger	O [ ] *		Babbles	O [ ] *		Waves 'bye bye'	O [ ] H [ ] *	
	Walks with support (cruising)			Picks up small objects between thumb and forefinger	O [ ] *		Speaks 3 words	O [ ] *		Drinks from cup	O [ ] H [ ] *	
15 months	Walks without support	O [ ] H [ ] *		Places objects in a cup	O [ ] H [ ] *		Speaks one word (other than mama-dada)	O [ ] H [ ] *		Shows shoes	O [ ] H [ ] *	
18 months	Climbs onto chairs	O [ ] H [ ] *		Points to eyes, nose and mouth	O [ ] H [ ] *		Speaks three words (other than mama, dada) with meaning	O [ ] H [ ] *		Takes off shoes and socks	O [ ] H [ ] *	
24 months	Runs	O [ ] H [ ] *		Builds a three block tower	O [ ] H [ ] *		Says own name	O [ ] H [ ] *		Takes off clothes	O [ ] H [ ] *	
	Kicks ball	O [ ] H [ ] *		Copies vertical line	O [ ] H [ ] *		Speaks 2 or 3 word phrase	O [ ] H [ ] *		Show or tells what he/she wants	O [ ] H [ ] *	
36 months	Jumps with both feet off the ground	O [ ] H [ ] *		Scribbles using fingers instead of fist	O [ ] H [ ] *		Names a friend	O [ ] H [ ] *		Dresses self but cannot do buttons	O [ ] H [ ] *	
		O [ ] H [ ] *		Holds pencil in writing position	O [ ] H [ ] *		Points at and names 6 body parts	O [ ] H [ ] *		Washes and dries hands	O [ ] H [ ] *	
48 months	Stands on one foot and balances self	O [ ] H [ ] *		Copies circle and cross	O [ ] H [ ] *		Listens attentively and obeys multiple instructions	O [ ] H [ ] *		Shares, follows rules and takes turns when playing	O [ ] H [ ] *	
	Throws ball over hand	O [ ] H [ ] *		Buttons and unbuttons clothing	O [ ] H [ ] *		Counts up to 10	O [ ] H [ ] *			O [ ] H [ ] *	

O = OBSERVED H = HISTORY * = UNABLE TO PERFORM

Feeding Notes

Guidelines for Infant and Young Child Feeding

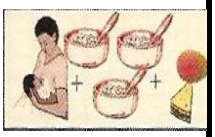
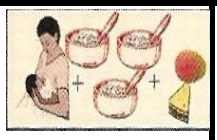
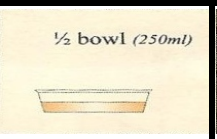
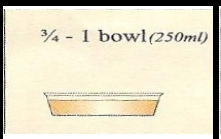
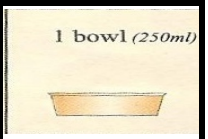
Child's Age	Type of Foods	How much & How often
Birth to 6 months	Practice exclusive breastfeeding (Breast milk alone). [*Do not give him other foods or fluids. Breast milk quenches your baby's thirst and satisfies his/her hunger. Exclusive breastfeeding protects your baby against diarrhea and other infectious diseases. Breastfeeding will also make your baby smarter!*]	Breastfeed as often as your baby wants, day and night. [*At least 8 times in 24 hours. Breastfeed when your baby shows signs of hunger: beginning to fuss, sucking fingers, or moving his lips.*]
At 6-8months	Continue breastfeeding Start other foods. Give soft, thick porridge made with milk to be fed with a spoon. Also offer well-mashed family foods. Mix a staple food (e.g. rice, bread, yam, green banana/fig, breadfruit) with other foods such as an animal food (meat, fish chicken, egg, milk), dark green leafy and yellow vegetables, peas and beans, and fats and oils. Offer small pieces of fruits too.	Breastfeed as often as baby wants, day and night. Start with 2-3 tablespoonfuls of other foods **2** times a day. Increase gradually to 1/2 cup.
At 9 -11 months	Continue breastfeeding Continue feeding a variety of foods. Give thick porridge and finely chopped or mashed family foods. Give foods high in iron like dark green leafy vegetables, meats, peas and beans Also offer foods that the child can pick up and chew. Avoid foods that can cause choking (nuts, raw carrots).	Breastfeed as often as possible Increase gradually to ½ bowl (250 mls) of other foods at meals **3 to 4** times a day. Add **1 to 2** snacks between meals.
At 12-24 months (1 -2 years)	Continue breastfeeding Continue feeding a variety of foods. Give thick porridge and chopped family foods. Give foods high in iron like dark green leafy vegetables, meats, peas and beans. Let the child try to feed himself or herself but give help.	Breastfeed as often as possible Increase gradually to a ¾ to full bowl (250 mls) of other foods at meals **3 to 4** times a day. Add 1 to 2 snacks between meals.
Between 2 -5 years	Give a mixture of family foods at meal times and healthy snacks between meals. Give foods high in iron like dark green leafy vegetables, meats, peas and beans. Offer full cream milk daily. Supervise the child at mealtimes, encourage him or her to eat and give help.	Give baby 3 to 4 meals, 1 bowl (250 mls) and1 to 2 snacks daily. Gradually increase the amount and the variety of foods at meals as baby gets older.

If the child is not breastfed, ask the health worker for advice on feeding him or her.

Recommendations for safe food preparation and hygiene to prevent illness:

- **Wash hands before preparing food, before feeding the baby, after changing baby's diaper and using the latrine or toilet.**
- **Obtain clean water for drinking and store in clean, covered containers.**
- **Wash child's feeding utensils thoroughly with soap and water or boil them.**
- **Keep food surfaces clean by using soap or detergent to clean them after each use.**

Recommendations for Feeding

Age of Child	0 to 6 mths (0-180 days)	6 mths to 8 mths	9 to 11 mths	12 to 23 mths	24 mths to 5 yrs
Frequency of Feeds					
	8 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 & Texture of Foods	**BREASTMILK ONLY**	Breast milk + Soft, thick porridge made with milk Well mashed family foods Mashed fruit	Breast milk + Soft, thick porridge made with milk Finely chopped or mashed family foods Mashed fruits Mashed meat, fish or egg	Breast milk + A variety of foods including thick porridge, chopped family foods and fruits	Breast milk + A variety of family foods and fruits Milk Orange & green vegetables
Amount of Food offered at each meal	Until baby comes off the breast	Begin with 2 to 3 tablespoons  Increasing gradually to ½ cup			

- Water must be given once formula, milk or food has been introduced.
- If child is not breastfed, ask the health worker for suggestions on feeding him or her.
- If child is sick, continue feeding and give more fluids (breastfeed more often), and encourage your child to eat more.
- Remember do feed your child with love, patience and good humour!

Key:	 Meals e.g. Porridge or food from family pot (before adding seasoning)
	 Snack e.g. Fruit, fruit juice

Your Child's Diet

Fill in the table below by asking mother/guardian about the food/drink eaten by the child on the day before the visit to the clinic/health facility. Record age of child in completed years and months.

Date dd/mm/yy	Age(years and months)	Breast milk (√)Y (×) N	Record other food/drink given to baby	Recommendations/suggestions

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Fill in the table below by asking mother/guardian about the food/drink eaten by the child on the day before the visit to the clinic/health facility. Record age of child in completed years and months.

Date dd/mm/yy	Age(years and months)	Breast milk (√)Y (×) N	Record other food/drink given to baby	Recommendations/suggestions

Your Child's Growth Measurements

Record the child's weight, length/height and head size. Write these in the spaces below along with any other important information about how the child is growing.

Date dd/mm/yy	Age(years and months)	Weight	Length/Height	Head circumference	Other

History of Allergies

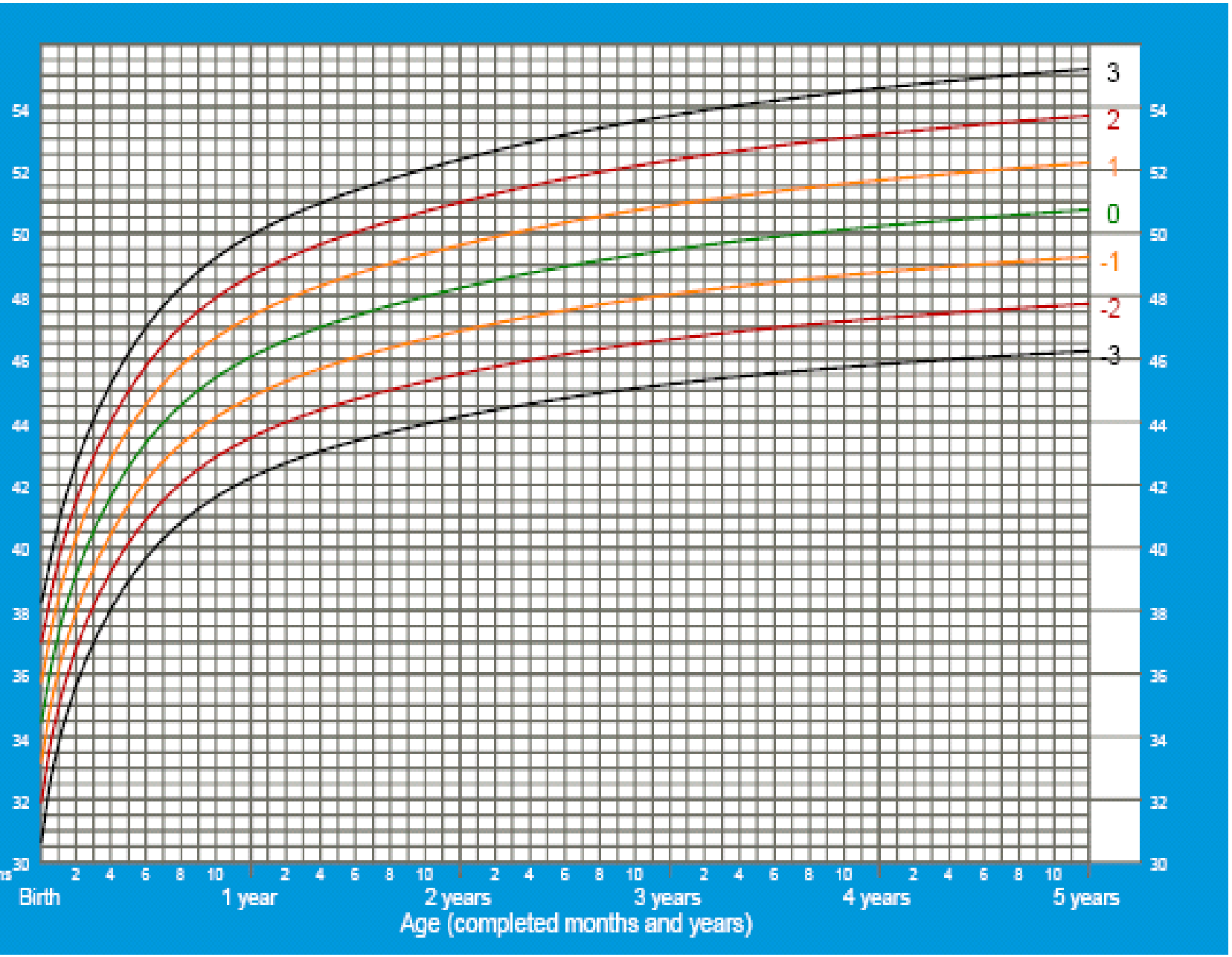
If the child has allergies, write in the spaces below what the child is allergic or sensitive to, at what age, what reactions she/he had, what treatment she/he needed.

Allergy (Foods & Others)	Age(years and months)	Reaction	Treatment

Head circumference-for-age BOYS

World Health Organization

Birth to 5 years (z-scores)

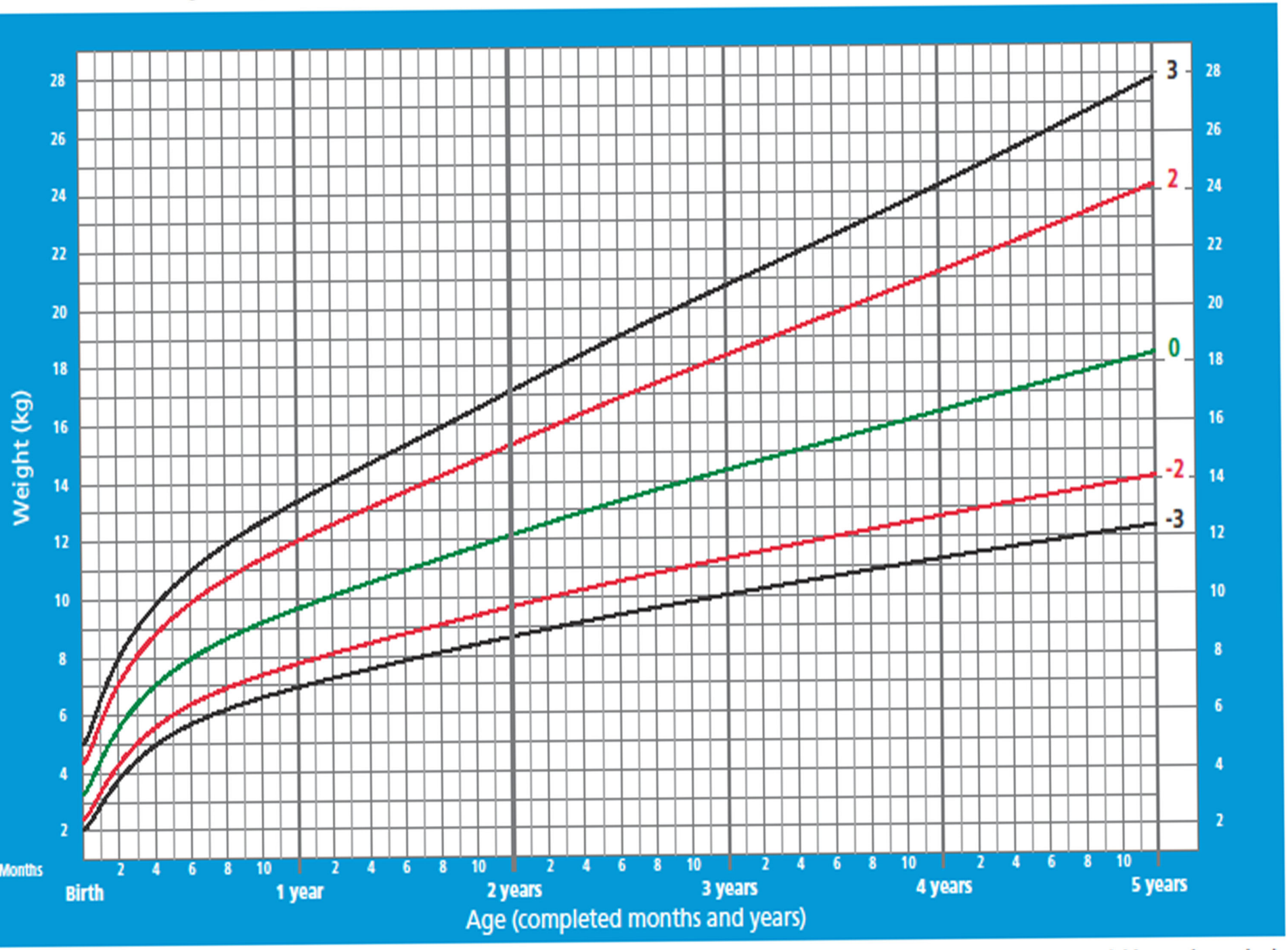


WHO Child Growth Standards

Weight-for-age BOYS

World Health Organization

Birth to 5 years (z-scores)

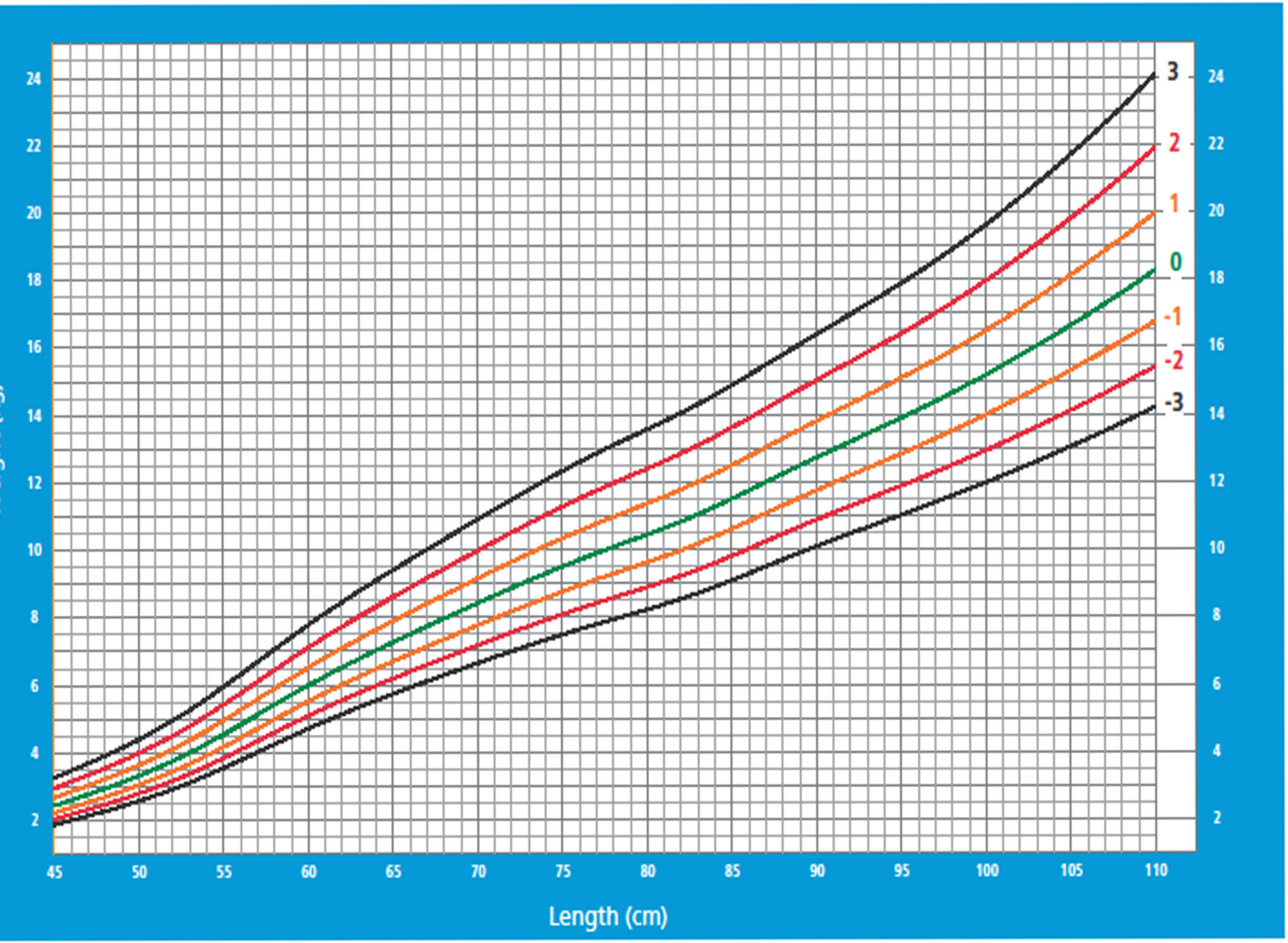


WHO Child Growth Standards

Weight-for-length BOYS

Birth to 2 years (z-scores)

World Health Organization

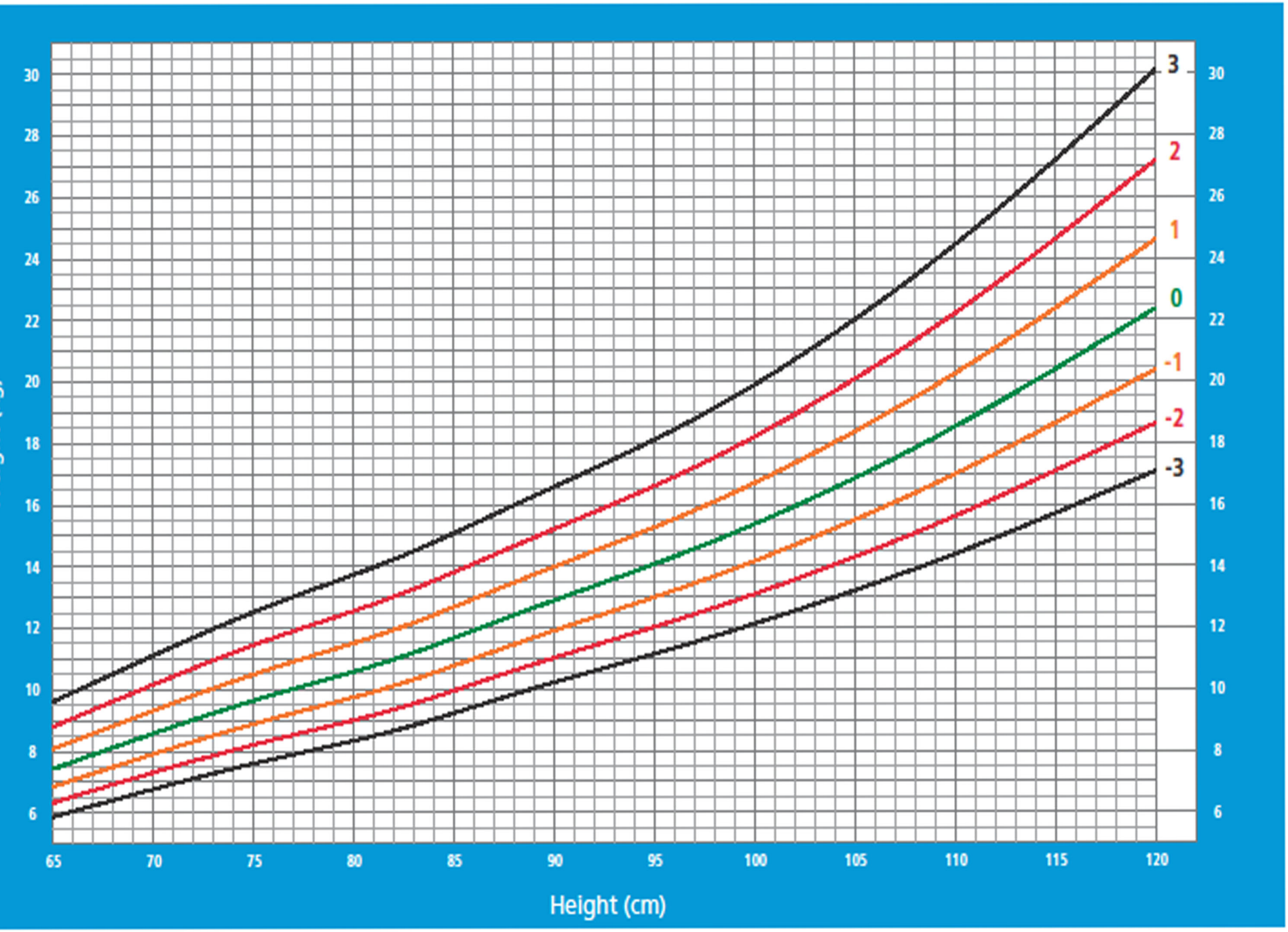


WHO Child Growth Standards

Weight-for-height BOYS

2 to 5 years (z-scores)

World Health Organization

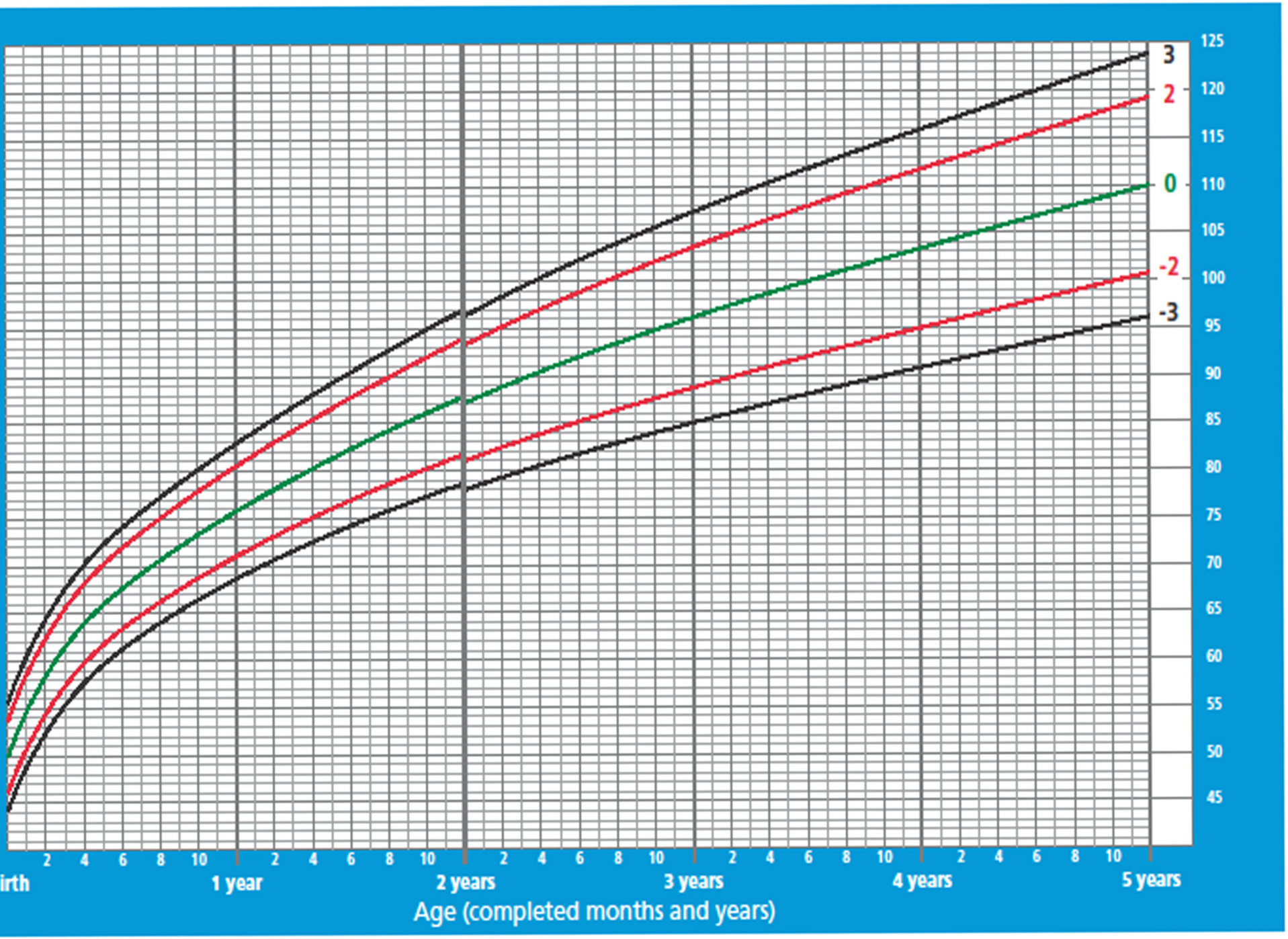


WHO Child Growth Standards

Length/height-for-age BOYS

Birth to 5 years (z-scores)

World Health Organization



WHO Child Growth Standards

Dental Health

Age when you started brushing your child's teeth? _____
Age when your child started brushing her/his teeth? _____
Age at first visit to the dentist/Dental Therapist?_____ (Age 1 is a good time to start)

REASON FOR REFERRAL: (Tick reasons for referral where applicable)
Dental Conditions
☐ Delayed Eruption Age (9 months old and older)
☐ Premature Eruption (before 4 months old)
☐ Premature Loss Of Teeth (before 4 years old)
☐ Crooked Teeth / Crowded Teeth
☐ Abnormal Bite
☐ **Cleft Lip**
☐ **Cleft Palate**
☐ Early Childhood Tooth Decay
☐ Severe Gum Bleeding or Swelling

In the space below, record any serious dental health problems the child has.

Date dd/mm/yy	Serious dental health problems	Treatment

Childhood Screening

	Dd /mm/ yy	AGE (years/months)	SCREENING	RECOMMENDATIONS
Hearing				
Vision				

Childhood Illnesses, Injuries and Referrals

Write any serious illnesses that this child has for more than one day such as chicken pox or ear infections.

Date Dd/mm/yy	Illness/Injury	Management (including medicine and hospitalization)	*Medication History (to include maintenance medication for any chronic condition)

* Medicines taken for more than one month

LIST OF IMMUNIZATIONS GIVEN

BCG

Protects against TB of the lungs, Meningitis and severe forms of TB. Given at birth.

DPT or DTaP

Protects against Diphtheria, Pertussis (whooping cough) and Tetanus.

Shots given at 2 months, 4 months and 6 months, Booster shots given at 18 months and 4 ½ - 6 years.

TOPV: Protects against Polio

Trivalent Oral Polio Vaccine

Given at the same time as DPT or DTaP

IPV (Not given routinely)

Injectable Polio Vaccine protects against Polio.

MMR

Protects against Measles, Mumps and Rubella. Given at 12 months and 4 - 6 years.

Hib

Protects against Haemophilus "B" influenza which cause meningitis. 4 doses given at 2, 4, 6 and 18 months.

Hep B

Protects against Hepatitis b infection. 3 doses given at 2, 4, and 6 months.

PCV

Protects against Pnemococcal infection, meningitis, pneumonia and bacterimia. 4 doses given at 2, 4, 6, and 12 months

DT

Protects against Diphtheria and Tetanus. Given instead of DPT at 18months, 3 years and 10-12 years.

VARICELLA

Protects against Chicken Pox. 2 doses given at 1year, and between 4 to 6 years.

If for various reasons you are unable to conform to this suggested time table, consult the nurse at the clinic or your own doctor who will modify the timetable to suit your baby's needs.

State possible adverse reactions:

Your Child's Immunization Schedule

Recommended Doses	Type of Vaccine	Batch No. / Lot No.	Manufacturer Country	Date of Immunization dd/mm/yy	Signature of person giving vaccine	Comment
At Birth	BCG					
	Hepatitis B (If Req'd)					
1st Dose	DPT/HepB/Hib					
(2 months)	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
2nd Dose	DPT/HepB/Hib					
(4 months)	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
3rd Dose	DPT/HepB/Hib					
(6 months)	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
1st Dose (12 months)	MMR					
	Varicella PCV					
BOOSTER DOSES						
1st Booster						
(18 months)	OPV or IPV					
	Hib					
	DPT/DTap					
2nd Booster	DPT/DTap					
3 years	DT					
	Varicella/ MMR					
10-12 years	DT/OPV					
Other Vaccines						

SCHOOL HEALTH: FIRST SCHOOL HEALTH VISIT **DATE OF EXAMINATION:**

SCHOOL: **GRADE:** **AGE:** **WEIGHT:** **HEIGHT:**

HEAD
HAIR
NECK/LYMPTH NODES
MUCOUS MEMBRANES
EYES
EARS
NOSE
THROAT
TEETH/ORAL CAVITY
LUNGS/THORAX
HEART
ABDOMEN
HERNIA
GENITALIA
MUSCULOSKELETAL
SKIN
NERVOUS SYSTEM /REFLEXES
COMMENTS AND TREATMENT:

PROGRESS NOTES (FOR REFERRALS ONLY)

IDENTIFICATION NO.: _____ **NAME OF CHILD:** _____ **DOB:** _____

DATE:		SIGNATURE

Notes for the main visits of the child to the Health Facility should include:

A. History of illness, injuries, hospital admission, vaccination status, behaviour and general nutrition of child.

B. Physical assessment should include nutritional status (weight, height, head circumference), skin, head, neck, eyes, ears, heart, lungs, abdomen, state of genitalia, neuro-muscular status.

C. Conclusions and risk factors should include physical health, motor development, speech/language, social/development, and behaviour.

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Please bring your child back for the next Clinic Appointment on:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____