

DOMINICA  
MINISTRY OF HEALTH

# Child Health Record

# Girls

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

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# General Information

Child's name \_\_\_\_\_ Identification Number \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Place of birth \_\_\_\_\_

Parents'/Guardian's name \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact (Name) \_\_\_\_\_ ( M )  
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
<b>Under 2 months</b>	Kicks legs when lying on back	O [ ] * [ ]		Opens hands	O [ ] * [ ]		Makes sounds other than crying	O [ ] * [ ]		Smiles in response	O [ ] * [ ]	
<b>2 months</b>	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 [ ] * [ ]	
<b>4 months</b>	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 [ ] * [ ]	
<b>6 months</b>	Rolls over when lying face up	O [ ] * [ ]		Reaches out to grasp objects	O [ ] * [ ]		Child turns head towards sounds on both sides	O [ ] * [ ]		Brings object to own mouth	O [ ] * [ ]	
	Bears weight on feet when add under arm	O [ ] * [ ]		Put in mouth	O [ ] * [ ]							
<b>9 months</b>	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 [ ] * [ ]										
<b>12 months</b>	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 [ ] * [ ]	
<b>15 months</b>	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 [ ] * [ ]	
<b>18 months</b>	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 [ ] * [ ]	
<b>24 months</b>	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 [ ] * [ ]	
<b>36 months</b>	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 [ ] * [ ]	
<b>48 months</b>	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



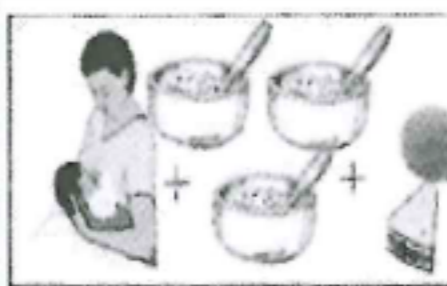






Child's Age	Type of Foods	How much & How often
Birth to 6 months	Practice exclusive breastfeeding (Breast milk alone). <i>[Do not give him other foods or fluids. Breast milk quenches your baby's thirst and satisfies his/her hunger. Exclusive breastfeeding protects your baby against diarrhea and other infectious diseases. Breastfeeding will also make your baby smarter!]</i>	Breastfeed as often as your baby wants, day and night. <i>[At least 8 times in 24 hours. Breastfeed when your baby shows signs of hunger: beginning to fuss, sucking fingers, or moving his lips.]</i>
At 6-8 months	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 1/2 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 3/4 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) and 1 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 teaspoons  Increasing gradually to 1/2 cup	1/2 bowl (250ml) 	1/4 - 1 bowl (250ml) 	1 bowl (250ml) 

- 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 (x)N	Record other food/drink given to baby	Recommendations/suggestions

## 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 (x) N	Record other food/drink given to baby	Recommendations/suggestions

## Your Child's Growth Measurements

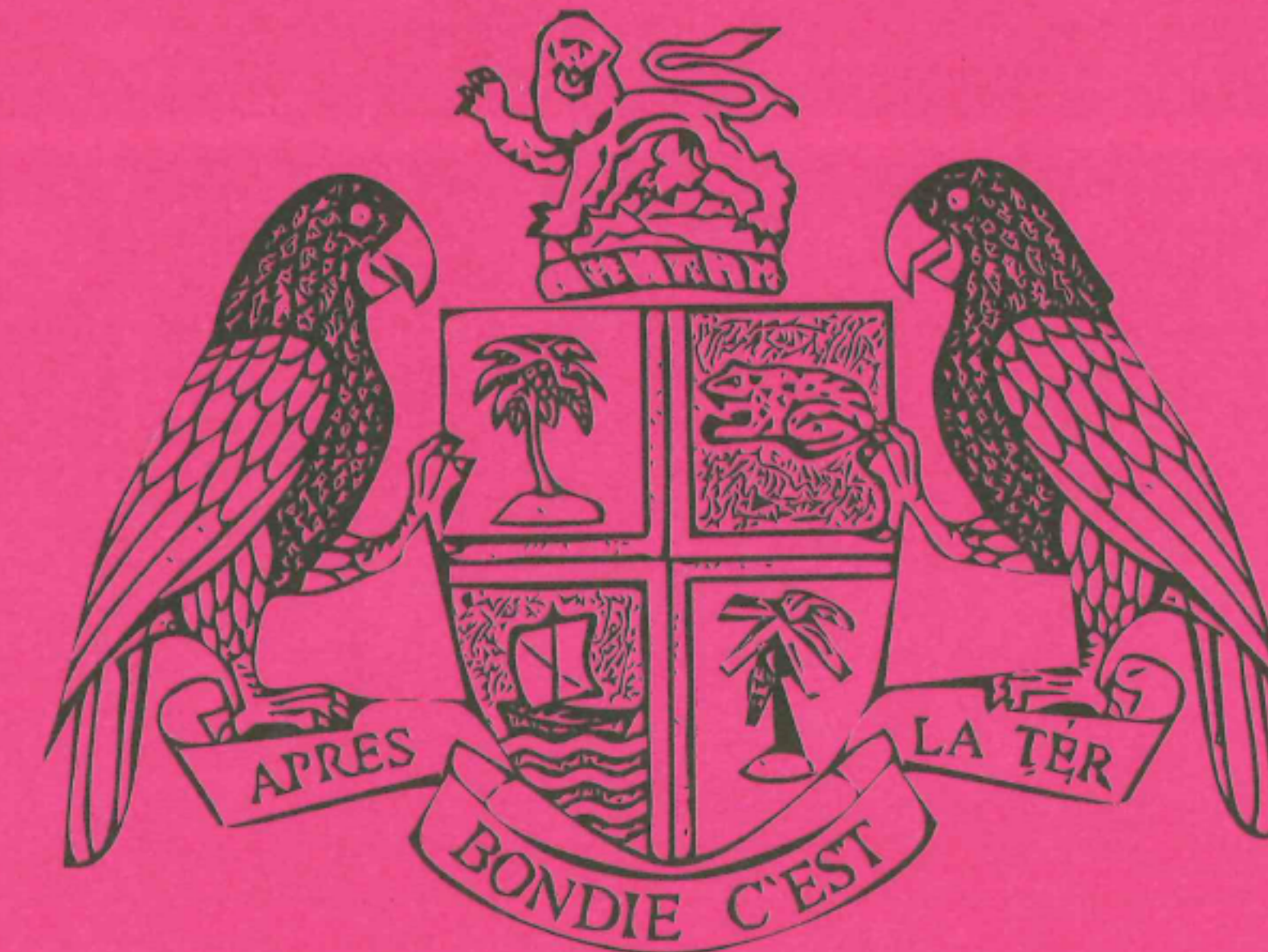
Record the child's weight, length/height and head size. Write these in the spaces below along with any other important information about how the child is growing.

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



**The Government of Dominica**



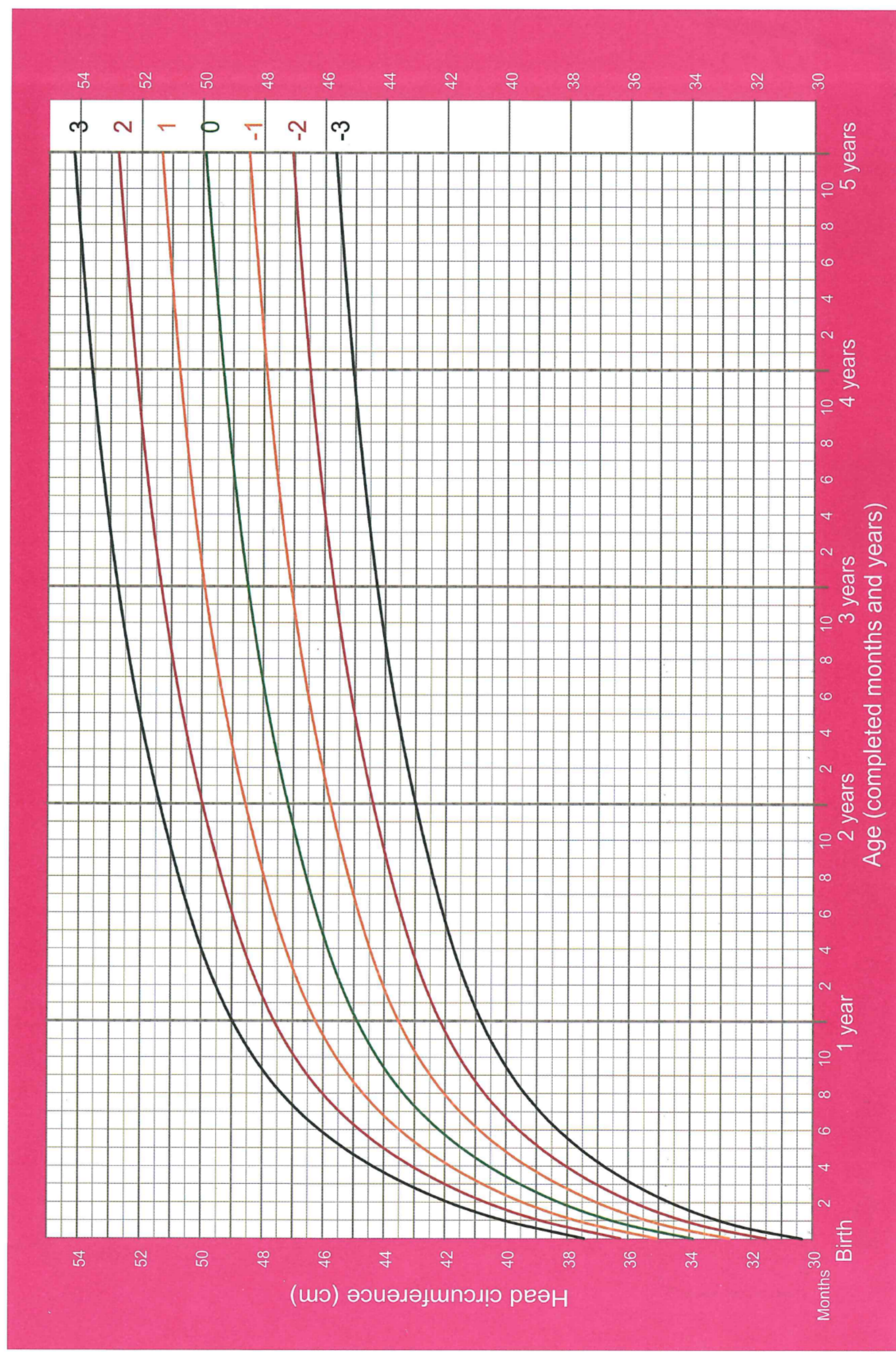
**World Health Organization**

**Child Growth Standards**

Name:

# Head circumference-for-age GIRLS

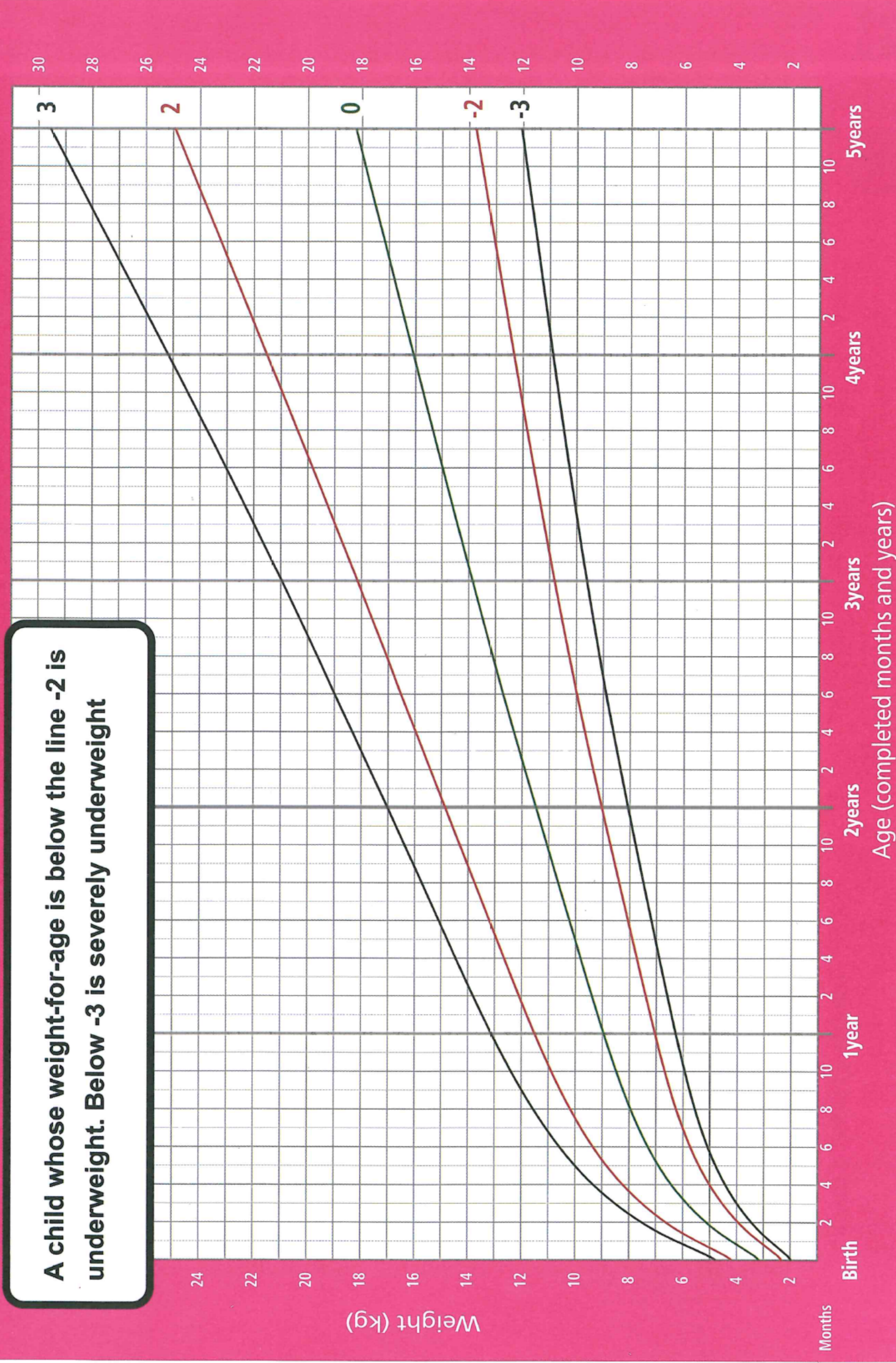
Birth to 5 years (z-scores)





# Weight-for-age GIRLS

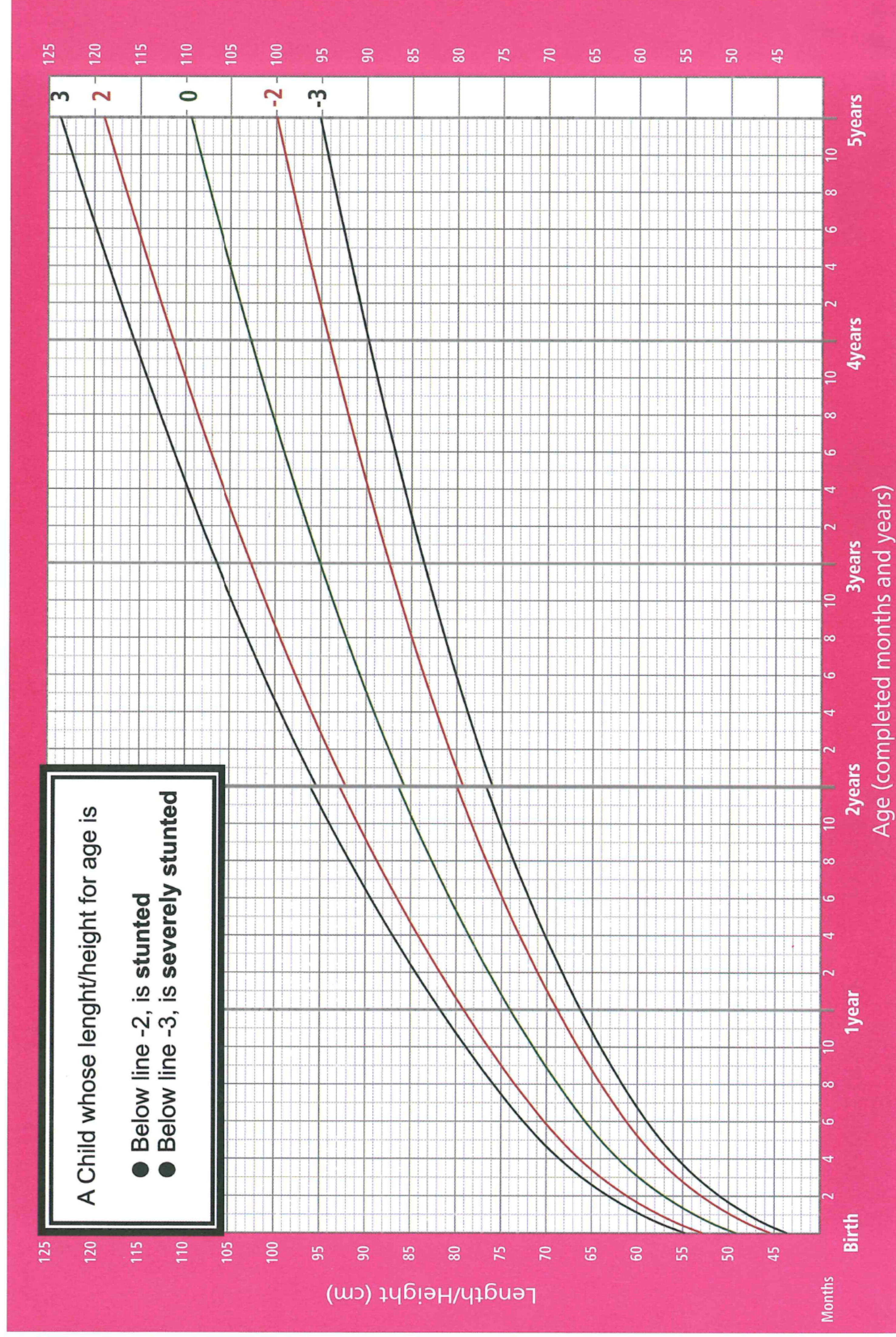
Birth to 5 years (z-scores)



WHO Child Growth Standards

# Length/height-for-age GIRLS

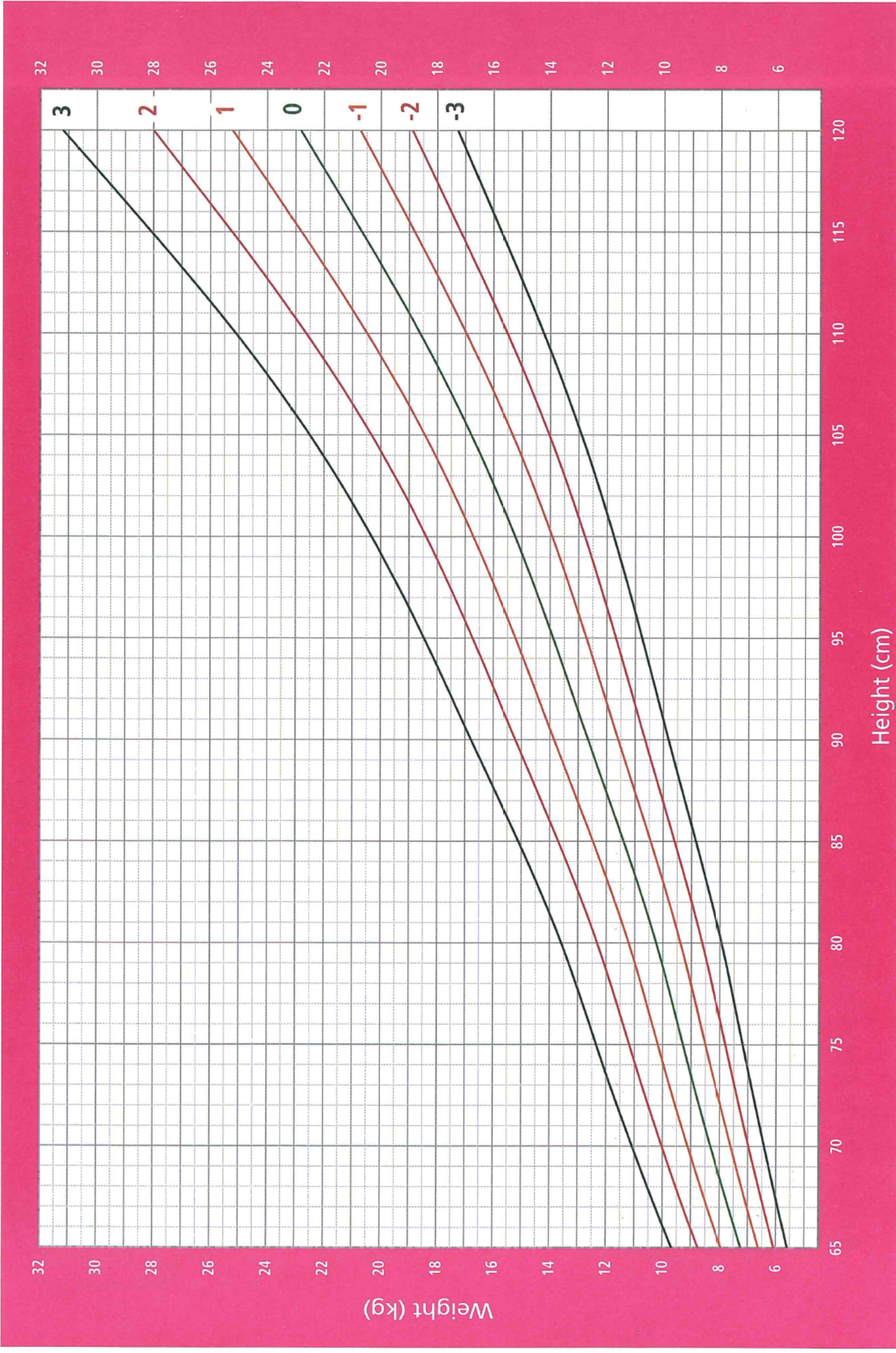
Birth to 5 years (z-scores)



WHO Child Growth Standards

# Weight-for-Height GIRLS

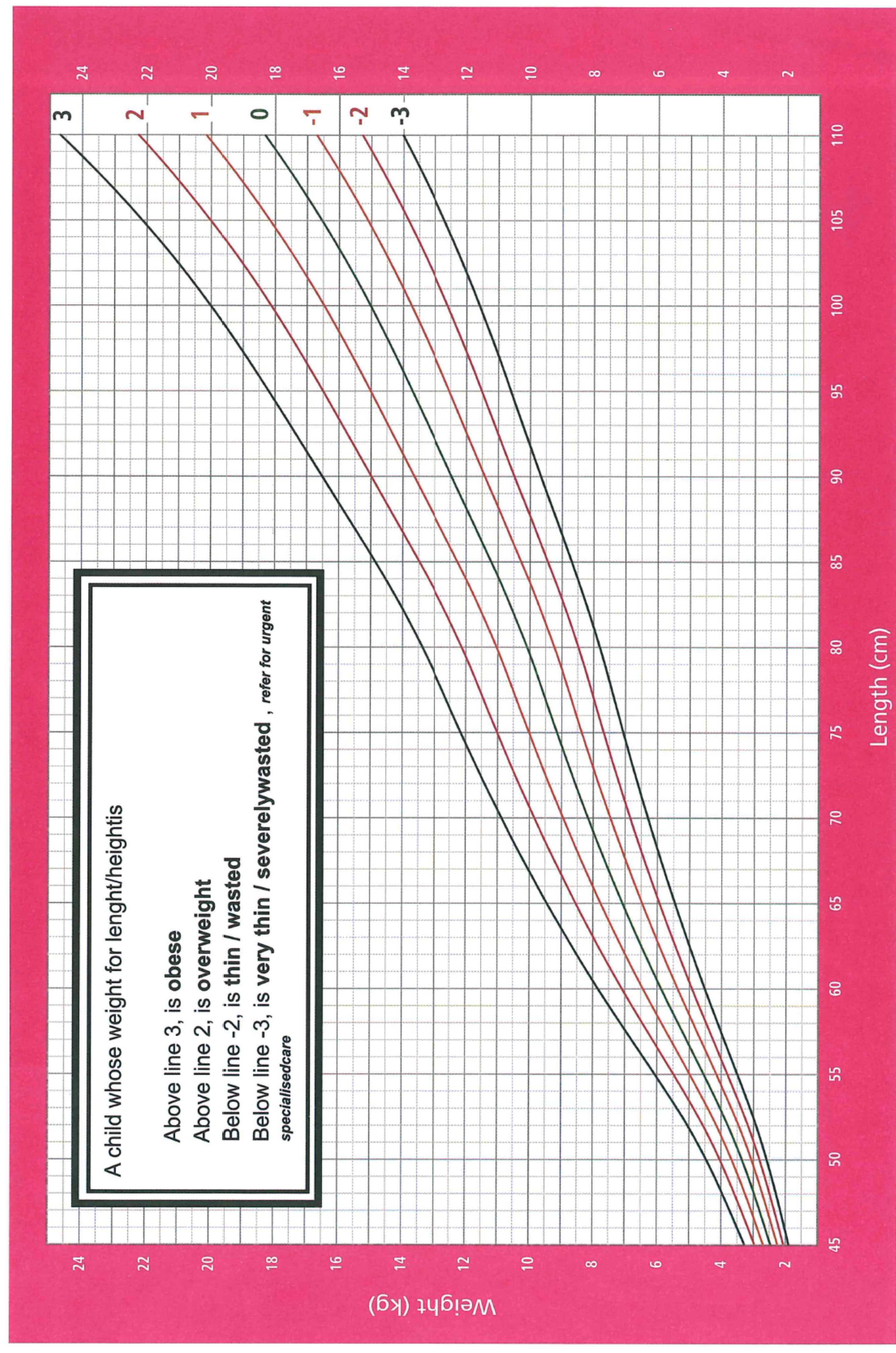
2 to 5 years (z-scores)



WHO Child Growth Standards

# Weight-for-length GIRLS

Birth to 2 years (z-scores)



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)

<b>REASON FOR REFERRAL:</b> (Tick reasons for referral where applicable)
<b>Dental Conditions</b>
<input type="checkbox"/> Delayed Eruption Age (9 months old and older)
<input type="checkbox"/> Premature Eruption (before 4 months old)
<input type="checkbox"/> Premature Loss Of Teeth (before 4 years old )
<input type="checkbox"/> Crooked Teeth / Crowded Teeth
<input type="checkbox"/> Abnormal Bite
<input type="checkbox"/> <b>Cleft Lip</b>
<input type="checkbox"/> <b>Cleft Palate</b>
<input type="checkbox"/> Early Childhood Tooth Decay
<input type="checkbox"/> 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

## EARLY STIMULATION ACTIVITIES

All children need care, support and appropriate developmental activities to help them grow and learn.

### Infants Birth to 18 months

- Gently hold, stroke and talk to your baby during feeding and when cared for by you.
- Smile as you look into babies face, gently talking to him/her making eye contact.
- Expose to bright , coloured , musical mobiles and soft, brightly coloured toys that make gentle sounds
- Encourage movement of limbs (kicking, grasping)
- Give clean toys –rattle, squeaky. Place on tummy to encourage movement of waving.
- Introduce to various types of soothing music
- Read to your baby, picture books (not much writing)
- Explain what you are doing during the day as you bathe, change and feed baby.
- Take the baby outside, point out things in the environment- a dog , flower, car, etc
- Place a bright happy picture of people and animals at eye level.
- Create a clean, safe place for baby to crawl, creep or walk, with toys within easy reach. (all toys must be clean, non toxic and with no removable parts.
- Play peek-a- boo, make animal sounds, imitate your baby's sounds, point out body parts and say the name- eyes, mouth etc.

### Toddlers 18months to 3 years

- Continue the activities in infancy and make adjustments to babies developmental needs
- Read short stories from books with clear, bright pictures
- Give blocks to stack and play dough to make shapes, soap bubbles to blow, puzzles with large pieces
- Play peek a- boo.
- Give paper and large crayons to encourage scribbling
- Provide large, safe areas for running, jumping and playing
- Hold stimulating conversation with your toddler
- Take the toddler to safe, child friendly and positively stimulating activities
- Begin teaching good habits saying thank you and please etc

**Pre School Child**

- Continue the above activities and make adjustments in keeping with the pre -school child's developmental needs
- Give toys like blocks, Lego and puzzles
- Provide clothing, unbreakable, washable dolls and toys for pretend play
- Provide balls, crayons, water paint, soap bubbles, play dough, colouring books, tricycle
- Read picture books and point out words and pictures, encouraging questions and discuss the story.
- Encourage their participation in hygiene routines –brushing teeth, washing and drying hands

**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:**

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## 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
<b>At Birth</b>	BCG					
	Hepatitis B (If Req'd)					
<b>1<sup>st</sup> Dose (2 months)</b>	DPT/HepB/Hib					
	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
<b>2<sup>nd</sup> Dose (4 months)</b>	DPT/HepB/Hib					
	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
<b>3<sup>rd</sup> Dose (6 months)</b>	DPT/HepB/Hib					
	Oral Polio Vaccine					
	DT					
	Hep B					
	Hib					
	IPV					
	DTaP/Hib/IPV					
	PCV					
<b>1<sup>st</sup> Dose (12 months)</b>	MMR					
	Varicella					
	PCV					
<b>BOOSTER DOSES</b>						
<b>1<sup>st</sup> Booster (18 months)</b>	OPV or IPV					
	Hib					
	DPT/DTap					
<b>2<sup>nd</sup> Booster (3 years)</b>	DPT/DTap					
	DT					
	Varicella/ MMR					
<b>10-12 years</b>	DT/OPV					
<b>Other Vaccines</b>						

**SCHOOL HEALTH: FIRST SCHOOL HEALTH VISIT**

**DATE OF EXAMINATION:**

**SCHOOL:**

**GRADE:**

**AGE:**

**WEIGHT:**

**HEIGHT:**

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



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

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____