



# Personal Data

Child's name: \_\_\_\_\_ Registration number: \_\_\_\_\_  
 Parent's name: S. A. ... Phone: \_\_\_\_\_  
 Address: ...  
 Gaurdian's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Doctor/Health Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

**Birth Information:**  
 Date of Birth: ... (dd/mm/yyyy) Place of Birth: ... Birth Rank: \_\_\_\_\_  
 Pre-term  Full Term  Post Term   
 Measurements at Birth: Weight 2.79 (kg) Length 49 cm (cm) HeadCirc. 34 (cm)  
 Type of birth: Normal  LSCS  Other (specify) C 34 cm,  
 Apgar score: 8.5 9.5  min Abc C 31.5 cm  
 Significant Health-related Problem: \_\_\_\_\_  
 Number of siblings: \_\_\_\_\_ Date of birth of youngest sibling: \_\_\_\_\_ (dd/mm/yy)

## ORAL HEALTH CHECKLIST

Age at first visit to the dentist (Between ages 1-3 years is a good time to start) \_\_\_\_\_

Tick reasons for referral where applicable

### REASONS FOR REFERRAL

DENTAL CONDITIONS	OCCURRENCES
No teeth present by 9 months old	<input type="checkbox"/>
Teeth present before 4 months old	<input type="checkbox"/>
Early loss of teeth before 4 years old	<input type="checkbox"/>
Crooked Teeth / Crowded Teeth	<input type="checkbox"/>
Abnormal Smile	<input type="checkbox"/>
Lack of Smile	<input type="checkbox"/>
Cleft Lip	<input type="checkbox"/>
Cleft Palate	<input type="checkbox"/>
Early Childhood Decay	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Severe Gum Bleeding or Swelling	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## IMMUNIZATION SCHEDULE (EPI)

Recommended Age & Doses	Type of Vaccine	Date of Immunization	Make	Batch #	Signature of health worker	Comment/ Adverse Reactions
At Birth or by 2 Months / 8 Weeks	BCG					
(2 Months) 1 <sup>st</sup> Dose	OPV					
	DPT					
	Hib					
	Hep B					
(4 Months) 2 <sup>nd</sup> Dose	OPV					
	DPT					
	Hib					
	Hep B					
(6 Months) 3 <sup>rd</sup> Dose	OPV					
	DPT					
	Hib					
	Hep B					
(12 Months) 1 <sup>st</sup> Dose	MMR					
<b>BOOSTER DOSES</b>						
18 Months 1 <sup>st</sup> Booster	OPV					
	DPT					
4 1/2 - 5 years 2 <sup>nd</sup> Booster	OPV					
	DT					
	MMR					
<b>CHILD IS FULLY IMMUNIZED FOR ENTRY TO PRIMARY SCHOOL</b> <input type="checkbox"/> Nurse's Signature: _____						
15 Years & over 3 <sup>rd</sup> Booster	Td (Adult)					
Other Vaccines						
Key:	BCG = Bacille Calmette Guerin; OPV = Oral Polio Vaccine;					
	Hib = Haemophilus Influenza Type B; HepB = Hepatitis B; DPT = Diphtheria, Pertussis, Tetanus Toxoid; DT = Diphtheria, Td= Tetanus Toxoid;					
	MMR = Measles, Mumps, Rubella.					

Age	Gross Motor	Age done	Fine Motor & Vision	Age done	Hearing & Speech	Age done	Social Behaviour & Play	Age done
6 Weeks-2 Months	Holds head up when lying down 0 []		Follows objects side to side with gaze 0 []		Listens to rattle 6" away at ear level 0 []		Gazes at your face 0 []	
4 Months	Lifts head and chest up when lying on stomach 0 []		Puts hands together and plays with them 0 []		Coos gurgles and squeals 0 []		Returns your smile 0 []	
6 Months	Bears weight on feet when held under arms 0 []		Reaches out to grasp 0 []		Babbles 0 []		Puts every-thing in mouth 0 []	
9 Months	Sits without support/crawls on hands and knees 0 []		Passes toy from hand to hand (transfers) 0 []		Shouts for attention 0 []		Finger feeds self 0 [] H []	
12 Months	Pulls to stand and walks alone holding on 0 []		Points with index finger 0 []		Speaks three words (other than ma da da) with meaning 0 []		Waves "bye bye" 0 []	
15 Months	Walks alone 0 [] H []		Picks up small objects between thumb and forefinger 0 []		Speaks 4-5 clear words 0 [] H []		Drinks from cup 0 [] H []	
18 Months	Climbs onto chairs 0 [] H []		Places one object on top of another 0 []		Points to eyes, nose and mouth 0 [] H []		Shows shoes 0 [] H []	
24 Months	Runs 0 [] H []		Turns pages 0 []		Says own name 0 [] H []		Takes off shoes and socks 0 [] H []	
36 Months	Climbs stairs 0 [] H []		Recognizes details in picture book 0 []		Speaks 2 or 3 word phrases 0 [] H []		Takes off clothes 0 [] H []	
48 Months	Kicks ball forward 0 [] H []		Copies vertical line 0 []		Names a friend 0 [] H []		Shows or tells what he/she wants 0 [] H []	
	Jumps with both feet off the ground 0 [] H []		Scribbles using fingers instead of fist 0 []		Points at and names 6 body parts 0 [] H []		Dresses self but cannot do buttons 0 [] H []	
	Stand on one foot and balances self 0 [] H []		Holds pencil in writing position 0 []		Listens 0 [] H []		Washes and dries hands 0 [] H []	
	Throws ball over hand 0 [] H []		Copies circles and cross 0 []		Counts up to 10 0 [] H []		Shares, follows rules and takes turns when playing 0 [] H []	

0 = Observed H = History

## Allergies:

Age	Allergy (Foods & Others)	Reaction	Advice / Referral

## Recommendations for Feeding

Age of Child	In first 6 mths (180 days)	6 mths to 8 mths	9 mths to 11 mths	12 mths to 23 mths	24 mths to 5 yr
Frequency	Day & night 	 If needed add: 	 If needed add: 	 If needed add: 	
Type of foods	Breastmilk only	•Breast milk + •Soft, thick porridge made with milk •Well- mashed family foods •Mashed fruit between meals	•Breast milk + •Soft, thick porridge made with milk •Finely chopped or mashed family foods •Mashed fruit between meals	•Breast milk + •A variety of foods including thick porridge chopped family foods and fruits	•A variety of family foods and fruits
Amount of food to offer at each meal	Until baby comes off the breast	Begin with 2-3 tablespoons  (Increase gradually to ½ cup)	½ bowl (250ml) 	¼ - 1 bowl (250ml) 	1 bowl (250ml) 

The bowl shown in the bottom row of the feeding recommendations should be the same size as a ½ lb margarine container

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

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

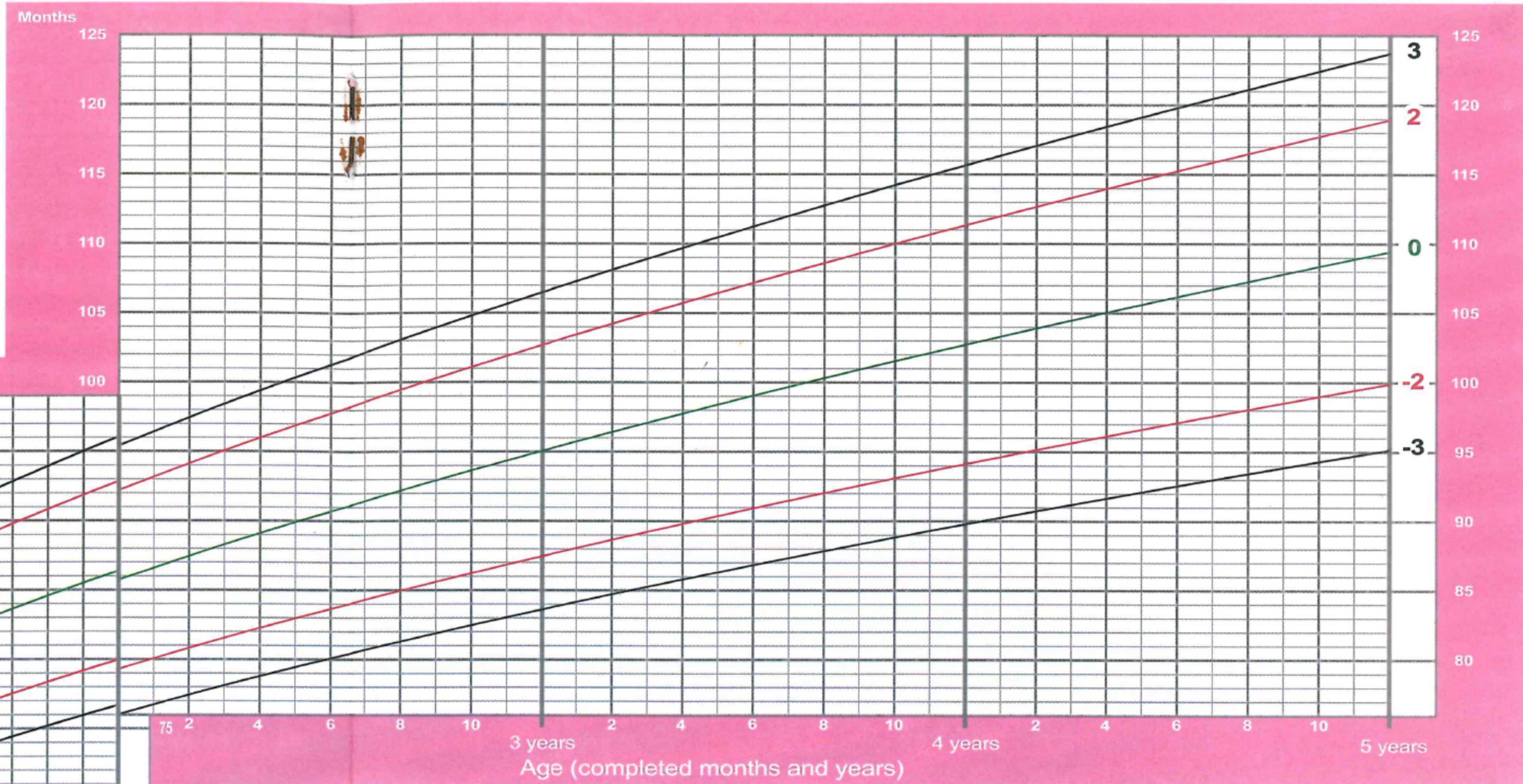
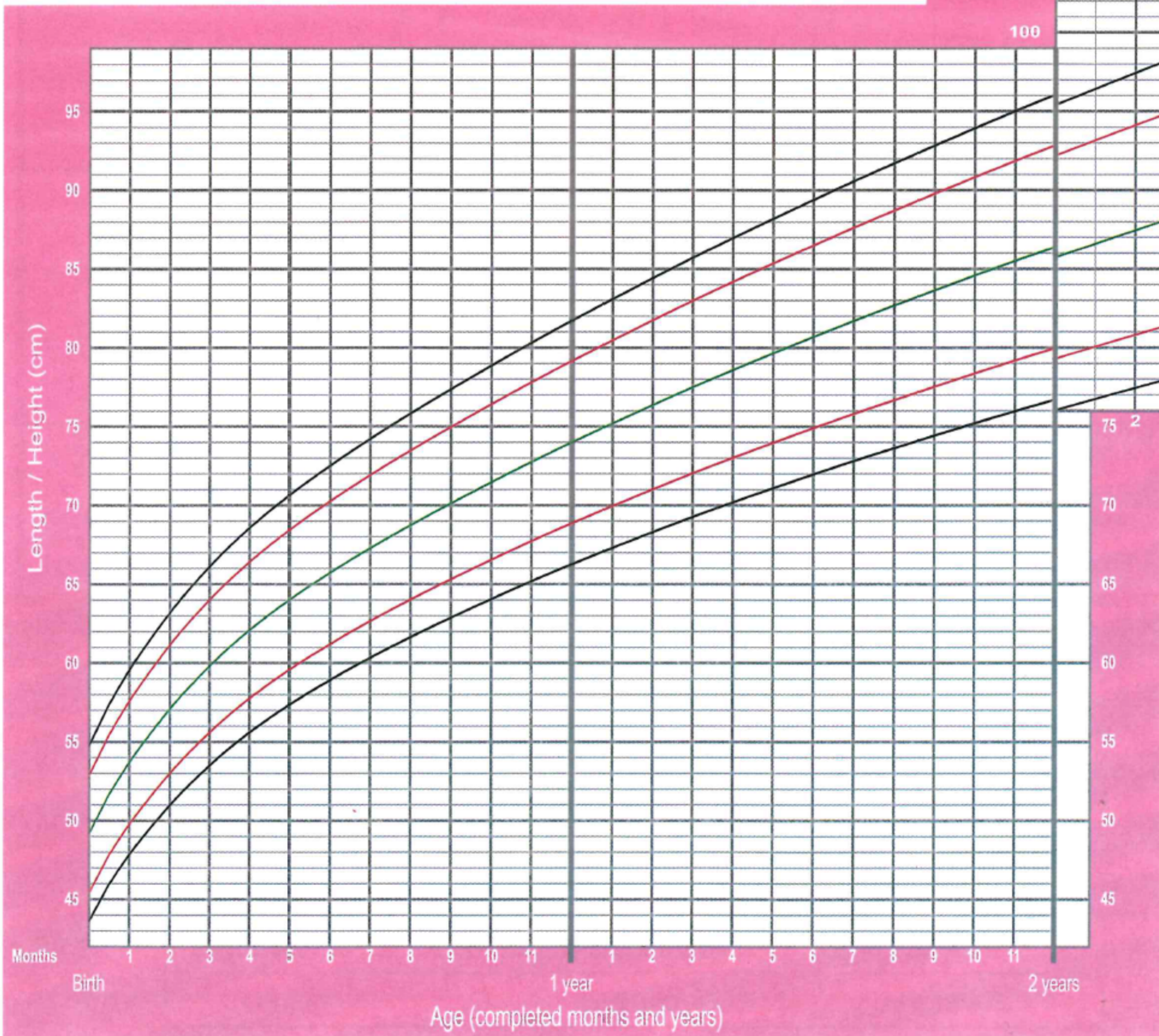
# Understanding Your Child's Growth Chart – Girl

## Length / Height-for-Age: Birth - 5 years (z - scores)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(dd/mm/yyyy)

Birth Weight: \_\_\_\_\_ (kg) Length: \_\_\_\_\_ (cm)

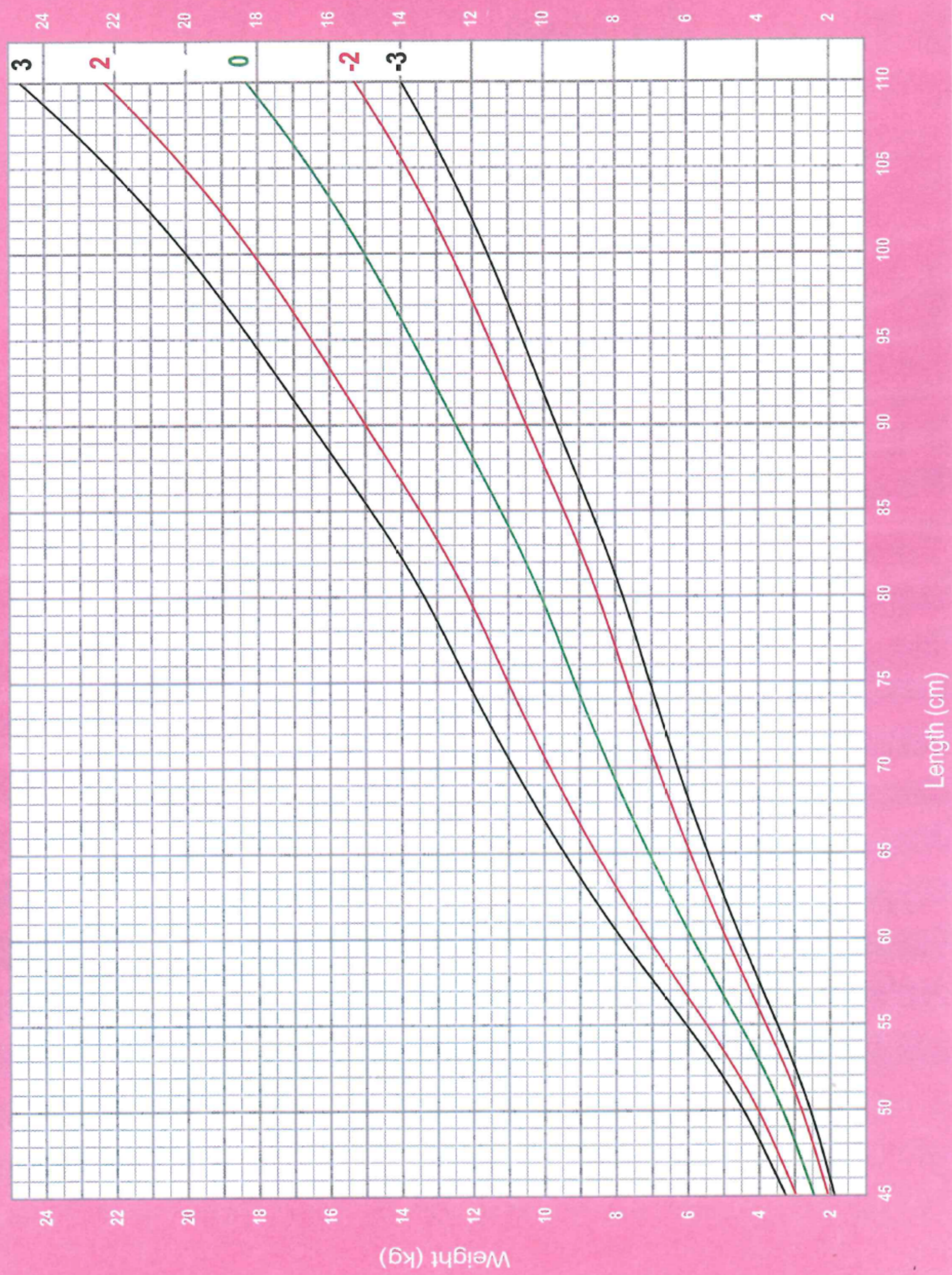


WHO Child Growth Standards



*Let your child play, move around, see, touch and explore. It helps her to learn and develop.*

# Weight-for-Length GIRLS Birth to 23 Months (z-scores)



WHO Child Growth Standards

# Weight-for-Height GIRLS 2 to 5 Years (z-scores)

