Parents as Teachers™

HEALTH *record*

> Child's name: _____ Birth date: _____

> Parent/guardian's name: _____ Birth weight: _____ (lbs.) _____ (ozs.)

> Date completed: Initial: _____ Second: _____ Third: _____

> Age/adjusted age of child: Initial: _____ Second: _____ Third: _____

> Immunization record provided or accessed: Initial: Y N Second: Y N Third: Y N

Health history

Was there difficulty during: Pregnancy? Y N Labor? Y N Delivery? Y N

Did your child have any special conditions at birth (born early, jaundice, medical diagnosis, etc.)? Y N

If yes, what was it? _____

Is there a possibility that your baby was exposed to neurotoxins before birth (such as alcohol, drugs, nicotine, or pesticides)? Y N

If yes, what was it? _____

Does your child have a current medical condition? If yes, please explain.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Does your child have allergies (any disease of the immune system that can cause an overreaction to substances like dust mites, pet dander, pollens, mold, foods, or insects)? If yes, please explain.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Does your child have asthma (a disease of the lungs in which the airways become blocked or narrowed, causing breathing difficulty)? If yes, please explain.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child had any illness with high fever (104ºF longer than two days)?

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Follow-up needed or actions taken:

Initial:

Second:

Third:

Parents as Teachers™

Health history (cont.)

Has your child visited the emergency room? If yes, please explain.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Does your child take medication regularly? If yes, what medication(s)?

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Is your child covered by a health insurance plan? If yes, please describe.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Does your child go to one place for regular medical check-ups and sick care? If so, where?

Initial: Y N _____
Second: Y N _____
Third: Y N _____

When was the last time your child received immunization shots?

Initial: _____
Second: _____
Third: _____

Are your child's immunizations records up to date? Initial: Y N Second: Y N Third: Y N

If not, did your child's healthcare provider mention upcoming immunizations?

Initial: Y N Second: Y N Third: Y N

According to your healthcare provider, are your child's size and weight OK? If there have been sudden jumps or drops, please explain.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child been screened for anemia? If yes, please describe the results.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Follow-up needed or actions taken:

Initial:

Second:

Third:

Parents as Teachers™

Safety review

Has your child been screened for lead levels? If yes, please describe the results.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Does your child ride in an approved car seat according to the state laws?

Rear-facing safety seat in the back seat? Initial: Y N Second: Y N Third: Y N
Forward-facing safety seat in the back seat? Initial: Y N Second: Y N Third: Y N

If your child is involved in biking or skating, is a helmet used?

Initial 1: Y N Second: Y N Third: Y N

Is your child exposed to second-hand smoke sometimes? If yes, please describe.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Is your home childproofed (for example, to prevent accidental poisoning, choking, and other injuries)?

Initial 1: Y N Second: Y N Third: Y N

Follow-up needed or actions taken:

Initial:

Second:

Third:

Dental review

> Date completed: Initial: _____ Second: _____ Third: _____

Does anything appear abnormal (swelling, redness, apparent decay) on the child's teeth or gums?

If yes, please describe.

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Is brushing teeth or cleaning gums part of your child's daily routine?

Initial: Y N Second: Y N Third: Y N

Does your child fall asleep with a bottle? Initial: Y N Second: Y N Third: Y N

Parents as Teachers™

Hearing review

> Date completed: Initial: _____ Second: _____ Third: _____

Did your child have a newborn screening? Y N If yes, what were the results? _____
Newborn screening record provided or accessed? Y N

Has your child had ear infections? If so, how many times per year and what was the treatment?

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child's hearing been checked by a healthcare provider? What were the results?

Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child had an audiology exam?

Initial: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Second: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Third: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Follow-up needed or actions taken:

Initial:

Second:

Third:

Parents as Teachers™

Hearing review (cont.)

Directions: Answer questions 1 to 8 for children under 2 years; answer questions 6 to 12 for children 2 years and older. A no answer for items 1 through 7 indicates the need for discussion and follow-up. A yes answer for items 8 through 12 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
1. Reacts to sudden loud noises.	Y N	Y N	Y N
2. Turns head toward interesting sounds or when his name is called.	Y N	Y N	Y N
3. Coos to himself and makes noise when he is alone.	Y N	Y N	Y N
4. Uses voice to get attention.	Y N	Y N	Y N
5. Tries to imitate you if you make his own sounds.	Y N	Y N	Y N
6. Seems to hear you if you talk in a whisper.	Y N	Y N	Y N
7. Seems to speak as well as other children the same age.	Y N	Y N	Y N
8. Has a family history of hearing problems.	Y N	Y N	Y N
9. Seems to have difficulty hearing.	Y N	Y N	Y N
10. Needs the television louder than other members of the family.	Y N	Y N	Y N
11. Seems to favor one ear over the other.	Y N	Y N	Y N
12. Makes you talk loudly or repeat frequently.	Y N	Y N	Y N

Follow-up needed or actions taken:

Initial:

Second:

Third:

Hearing screening (if applicable)

Directions: Record any hearing screening completed. Indicate P for pass or R for refer.

	Initial		Second		Third	
	Right	Left	Right	Left	Right	Left
Hearing screening/OAE						
Tympanogram						
Audiometry						

Parents as Teachers™

Vision review

> Date completed: Initial: _____ Second: _____ Third: _____

Has your child ever had a vision check by a doctor?

Initial: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Second: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Third: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Directions: A yes answer for any item 1 through 12 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
1. Has eyes crossed – turning in or out – at any time, or eyes that do not appear straight, especially when the child is tired.	Y N	Y N	Y N
2. Has reddened eyes or eyelids.	Y N	Y N	Y N
3. Has encrusted eyelids.	Y N	Y N	Y N
4. Has frequent sties (pimple on the eyelid).	Y N	Y N	Y N
5. Has eyes that appear to move more than other people's eyes do.	Y N	Y N	Y N
6. Has eyelids that droop.	Y N	Y N	Y N
7. Has white spots or cloudiness covering some or all of the center of the eye.	Y N	Y N	Y N
8. Complains of burning, itching, or pain in eyes.	Y N	Y N	Y N
9. Stares at bright lights frequently or repeatedly flicks objects in front of face.	Y N	Y N	Y N
10. Is bothered by light more than you are.	Y N	Y N	Y N
11. Exhibits a pupil, the dark center part of the eye, that seems larger or smaller than the pupil in other children's eyes.	Y N	Y N	Y N
12. Complains of headache or nausea.	Y N	Y N	Y N

Follow-up needed or actions taken:

Initial:

Second:

Third:

Parents as Teachers™

Vision review (cont.)

A yes answer for three or more items on 13 through 23 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
13. Has watery eyes.	Y N	Y N	Y N
14. Complains of tired eyes; rubs eye often.	Y N	Y N	Y N
15. Moves the head forward or backward while looking at distant objects.	Y N	Y N	Y N
16. Turns the head to use one eye only (closes or covers one eye).	Y N	Y N	Y N
17. Tilts the head to one side often or all the time.	Y N	Y N	Y N
18. Places an object close to the eyes to look at it.	Y N	Y N	Y N
19. Squints while looking at objects.	Y N	Y N	Y N
20. Blinks more than you do.	Y N	Y N	Y N
21. Has difficulty walking or running; trips over objects more often than others do.	Y N	Y N	Y N
22. Is unable to see distant objects.	Y N	Y N	Y N
23. Has a family history of lazy eye or vision problems.	Y N	Y N	Y N

Functional assessment

Directions: To be completed by screener. Indicate P for present or A for absent.

	Initial		Second		Third	
	Right	Left	Right	Left	Right	Left
Blink Reflex						
Pupillary Response						
Corneal Light Reflex						
Tracking						
Reaching						

Other screenings (such as acuity screening for children over 2½ years of age):

Initial: _____

Second: _____

Third: _____

Follow-up needed or actions taken:

Initial:

Second:

Third: