

# Module 1: What Is Well-Child Health Care and Why Is It Important?

## Handout C: Child Health Record Sample (Part 1)

### CHILD HEALTH RECORD:

### FORM 2A, HEALTH HISTORY

PERSON INTERVIEWED: <u>JEAN BROWN</u>		DATE: <u>3-1-96</u>	RELATIONSHIP: <u>MOTHER</u>
NAME OF INTERVIEWER: _____		TITLE: _____	
<b>PREGNANCY/BIRTH HISTORY</b>		YES	NO
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		EXPLAIN "YES" ANSWERS	
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. WHAT WAS CHILD'S BIRTH WEIGHT?		<u>7</u>	<u>2</u>
		lbs.,	oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. IS MOTHER PREGNANT NOW?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)	
<b>HOSPITALIZATIONS AND ILLNESSES</b>		YES	NO
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		EXPLAIN "YES" ANSWERS	
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		asthma	
<b>HEALTH PROBLEMS</b>		YES	NO
13. DOES CHILD HAVE FREQUENT _____ SORE THROAT; <input checked="" type="checkbox"/> COUGH; _____ URINARY INFECTIONS OR TROUBLE URINATING; _____ STOMACH PAIN, VOMITING, DIARRHEA?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		EXPLAIN (Use additional sheets if needed)	
14. DOES CHILD HAVE DIFFICULTY SEEING (Squint, cross eyes, look closely at books)?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. IS CHILD WEARING (or supposed to wear) GLASSES?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		(If "yes") WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____	
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		ear infections as baby	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND (Rear end, anus, butt) WHILE ASLEEP?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		If "yes" ask: WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____	
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? (Special consent form must be signed for Head Start to administer any medication).		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		WHAT MEDICINE? _____ (If "yes") WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _____	
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		(PHYSICIAN'S NAME: <u>MARY SMITH</u> )	
21. HAS CHILD HAD: _____ BOILS, <input checked="" type="checkbox"/> CHICKENPOX, <input checked="" type="checkbox"/> ECZEMA, _____ GERMAN MEASLES, _____ MEASLES, _____ MUMPS, _____ SCARLET FEVER, _____ WHOOPING COUGH?		<input type="checkbox"/>	<input type="checkbox"/>
22. HAS CHILD HAD: <input checked="" type="checkbox"/> HIVES, _____ POLIO?		<input type="checkbox"/>	<input type="checkbox"/>
		When ate peanut butter	
23. HAS CHILD HAD: <input checked="" type="checkbox"/> ASTHMA, _____ BLEEDING TENDENCIES _____ DIABETES, _____ EPILEPSY, _____ HEART/BLOOD VESSEL DISEASE, _____ LIVER DISEASE, _____ RHEUMATIC FEVER, _____ SICKLE CELL DISEASE?		<input type="checkbox"/>	<input type="checkbox"/>
		If "yes", transfer information to Forms 1 and 5. Since age 2 - mostly IN WINTER; some with animals	
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS (Rash, itching, swelling, difficulty breathing, sneezing)?		<input type="checkbox"/>	<input type="checkbox"/>
a. WHEN EATING ANY FOODS? <input checked="" type="checkbox"/>		If "yes", transfer information to Forms 1 and 5. WHAT FOODS? <u>peanuts</u>	
b. WHEN TAKING ANY MEDICATION? _____		WHAT MEDICINE? _____	
c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____		WHAT THINGS? <u>animals</u>	
		HOW DOES CHILD REACT? <u>RASH, ITCH, cough</u>	
25. (If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:) DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		DESCRIBE HOW: <u>coughing &amp; colds IN WINTER</u>	
DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
		WHEN? <u>Age 2 - asthma</u>	
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		DESCRIBE: _____	
DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		WHEN? _____	

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.

# Module 1: What Is Well-Child Health Care and Why Is It Important?

## Handout C: Child Health Record Sample (Part 1, continued)

### CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92  
 HEAD START CENTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):  
Allergy to peanuts/peanut butter

2. SCREENING TESTS. Starred items (\*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE*	<u>3-24-96</u>	____ Yrs., ____ Mos.	g. VISION (Type of Test)*		<u>SNELLEN</u>
b. HEIGHT (no shoes, to nearest 1/8 in.)*			ACUITY, R/L	<u>3-24-96</u>	<u>20/25 R, L</u>
c. WEIGHT (light clothing to nearest 1/4 lb.)*			RESCREENING		
d. BLOOD PRESSURE			STRABISMUS	<u>11</u>	<u>NL</u>
e. HEMATOCRIT or HEMOGLOBIN*	<u>3-24-96</u>	<u>11.6</u>	COMMENTS		
f. HEARING (Type of Test)*		<u>AUDIOMETRY</u>	h. OTHER TESTS (if indicated)	<u>3-24-96</u>	<u>NEG.</u>
RESULTS, R/L	<u>3-24-96</u>	<u>NL</u>	(1) TB		
RESCREENING			(2) Sickie Cell		
COMMENTS			(3) Lead	<u>3-24-96</u>	<u>12 REDRAWN 9/19/96</u>
			(4) Ova & Parasites		
			(5) Urinalysis		
			(6) Other		

PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION/ASSESSMENT. Complete and return top three copies to Head Start.

	NORMAL FOR AGE	ABNOR-MAL	NOT EVAL.	COMMENTS (Use Additional sheet if necessary)
a. GENERAL APPEARANCE	<input checked="" type="checkbox"/>			
b. POSTURE, GAIT	<input checked="" type="checkbox"/>			
c. SPEECH			<input checked="" type="checkbox"/>	<u>NOT ABLE TO ASSESS</u>
d. HEAD	<input checked="" type="checkbox"/>			
e. SKIN	<input checked="" type="checkbox"/>			
f. EYES: (1) External Aspects	<input checked="" type="checkbox"/>			
(2) Optic Fundiscopic	<input checked="" type="checkbox"/>			
(3) Cover Test	<input checked="" type="checkbox"/>			
g. EARS: (1) External & Canals	<input checked="" type="checkbox"/>			
(2) Tympanic Membranes	<input checked="" type="checkbox"/>			
h. NOSE, MOUTH, PHARYNX				
i. TEETH		<input checked="" type="checkbox"/>		<u>UPPER FRONT TEETH DECAYED</u>
j. HEART	<input checked="" type="checkbox"/>			
k. LUNGS	<input checked="" type="checkbox"/>			
l. ABDOMEN (include hernia)	<input checked="" type="checkbox"/>			
m. GENITALIA	<input checked="" type="checkbox"/>			
n. BONES, JOINTS, MUSCLES	<input checked="" type="checkbox"/>			
o. NEUROLOGICAL/SOCIAL				
(1) Gross Motor	<input checked="" type="checkbox"/>			
(2) Fine Motor	<input checked="" type="checkbox"/>			
(3) Communication Skills	<input checked="" type="checkbox"/>			
(4) Cognitive	<input checked="" type="checkbox"/>			
(5) Self-Help Skills	<input checked="" type="checkbox"/>			
(6) Social Skills	<input checked="" type="checkbox"/>			
p. GLANDS (Lymphatic/Thyroid)	<input checked="" type="checkbox"/>			
q. MUSCULAR COORDINATION	<input checked="" type="checkbox"/>			
r. OTHER				

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:  
 Signature: M. Smith, M.D. Date: 3-24-96

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS (Initial when complete)	DATE
a. <u>DENTAL CARRIES</u>	<u>REF. TO DENTIST</u>		
b.			
c.			
d.			

For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.

# Module 1: What Is Well-Child Health Care and Why Is It Important?

## Handout C: Child Health Record Sample (Part 2)

**CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT**

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92  
 HEAD START CENTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_

**1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):**  
Allergy to peanuts/peanut butter

**2. SCREENING TESTS. Starred items (\*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.**

TEST	DATE	RESULTS	TEST	DATE	RESULTS
			g. VISION (Type of Test)*		<u>SNELLEN</u>
			ACUITY, R/L	<u>3-24-96</u>	<u>20/25 R, L</u>
			RESCREENING		
			STRABISMUS	<u>11</u>	<u>NL</u>
			COMMENTS		
e. HEMATOCRIT or HEMOGLOBIN*	<u>3-24-96</u>	<u>11.6</u>	h. OTHER TESTS (if indicated)	<u>3-24-96</u>	<u>NEG.</u>
f. HEARING (Type of Test)*		<u>AUDIOMETRY</u>	(1) TB		
RESULTS, R/L	<u>3-24-96</u>	<u>NL</u>	(2) Sickle Cell		
RESCREENING			(3) Lead	<u>3-24-96</u>	<u>12 REDUCTION 9/19/96</u>
COMMENTS			(4) Ova & Parasites		
			(5) Urinalysis		
			(6) Other		

Immunizations	Birth to 1 Month	2 Months	4 Months	6 Months	12-18 Months	4-6 Years
DTP		<u>5-17-92</u>	<u>8-28-92</u>	<u>11-3-92</u>	<u>8-1-93</u>	<u>3-24-96</u>
Polio		<u>5-17-92</u>	<u>8-28-92</u>		<u>8-1-93</u>	<u>3-24-96</u>
HIB		<u>5-17-92</u>	<u>8-28-92</u>	<u>11-3-92</u>	<u>8-1-93</u>	
Hep B						
MMR					<u>8-1-93</u>	<u>3-24-96</u>
Other						

*Note: Ages and number of boosters may vary when immunizations start at older ages.*

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.

# Module 1: What Is Well-Child Health Care and Why Is It Important?

## Handout C: Child Health Record Sample (Part 3)

### CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: JEAN BROWN DATE: 3-1-96 RELATIONSHIP: Mother  
 NAME OF INTERVIEWER: \_\_\_\_\_ TITLE: \_\_\_\_\_

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT  
 THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?  
Likes climbing structures at park  
Likes Dressing up & acting

28. DOES YOUR CHILD TAKE A NAP?  NO;  YES. IF "YES" DESCRIBE WHEN AND HOW LONG. 1 hr. - pm

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)?  NO;  YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? goes by self

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS?  NO;  YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW? a little shy

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE? likes to play

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN? a little shy

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING?  NO;  YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID? VERY SAD when parents fighting & split-up

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. (INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).

	EARLIER	WHEN EXPECTED	LATER	AGE
a. WOULD YOU SAY YOUR CHILD BEGAN TO _____ EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?		<input checked="" type="checkbox"/>		<u>5 MO</u>
(a) SIT UP WITHOUT HELP		<input checked="" type="checkbox"/>		<u>5 MO</u>
(b) CRAWL		<input checked="" type="checkbox"/>		<u>7 MO</u>
(c) WALK		<input checked="" type="checkbox"/>		<u>11 MO</u>
(d) TALK	<input checked="" type="checkbox"/>			<u>18 MO</u>
(e) FEED AND DRESS SELF		<input checked="" type="checkbox"/>		<u>1-2 YR</u>
(f) LEARN TO USE THE TOILET		<input checked="" type="checkbox"/>		<u>2 YR</u>
(g) RESPOND TO DIRECTIONS		<input checked="" type="checkbox"/>		<u>1 YR</u>
(h) PLAY WITH TOYS		<input checked="" type="checkbox"/>		<u>1 YR</u>
(i) USE CRAYONS		<input checked="" type="checkbox"/>		<u>2 YR</u>
(j) UNDERSTAND WHAT IS SAID TO HIM/HER	<input checked="" type="checkbox"/>			<u>1 YR</u>

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD?  NO;  YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY?  NO;  YES. IF "YES" CAN YOU TELL ME ABOUT THAT?  
 WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS?  NO;  YES. IF "YES" PLEASE DESCRIBE. split-up with husband  
New baby at home

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD?  NO;  YES. IF "YES" PLEASE DESCRIBE. split-up with husband  
finances

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD?  NO;  YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.



# Module 1: What Is Well-Child Health Care and Why Is It Important?

## Handout C: Child Health Record Sample (Part 5)

### CHILD HEALTH RECORD:

### FORM 6, NUTRITION

CHILD'S NAME: JANINE BROWN SEX: F BIRTHDATE: 3-10-92

DIETARY HABITS  
1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE? Hamburguees, fries, juice, soda

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES? green vegetables, milk

		Yes	No			Approximate Number of Times a Week (circle the number(s) nearest to parent's answer)										
3.	DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS? (a) If "yes", what kind are they? (b) Do they contain iron? (c) Do they contain fluoride? (d) Were they prescribed?		<input checked="" type="checkbox"/>			12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?										
	(a) Milk, cheese, yogurt.					(a)	0*	1*	2*	3	4	5	6	7	7+	
	(b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter.					(b)	0*	1*	2*	3	4	5	6	7	7+	
	(c) Rice, grits, bread, cereal, tortillas.					(c)	0*	1*	2*	3	4	5	6	7	+	
	(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.					(d)	0*	1*	2	3	4	5	6	7	7+	
	(e) Oranges, grapefruit, tomatoes (fruit juice).					(e)	0*	1*	2*	3	4	5	6	7	7+	
	(f) Other fruits and vegetables.					(f)	0*	1	2	3	4	5	6	7	7+	
	(g) Oil, butter, margarine, lard.					(g)	0*	1*	2	3	4	5	6	7	7+*	
	(h) Cakes, cookies, sodas, fruit drinks, candy.					(h)	0	1	2	3	4	5	6	7	7+*	

\*Starred answers may require follow-up. Explain details or give additional comments here.

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

13. GROWTH				14. ANEMIA SCREEN			
DATE	AGE	HEIGHT (no shoes, to nearest 1/8 in.)	WEIGHT (light clothing, to nearest 1/4 lb.)		DATE	HEMOGLOBIN*	OR HEMATOCRIT *
2/24/96	1 yrs. 11 mo.	25" (50th)	24 lb. (25th)	SCREENING	3/24/96	11.6	
4/30/96	3 yrs. 1 mo.	37 1/2" (50th)	28 lb. (15th)	RESCREENING			
8/24/96	4 yrs. 0 mo.	40" (50th)	29 lb. (5th)				

\*Hgb less than 11 or Hct less than 34 require follow-up

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION  
(Review items 2 through 13. If there are answers in starred (\*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

<input type="checkbox"/> Suspect dietary problem or inadequate food intake (from Questions 2 to 12)	<input type="checkbox"/> Overweight (weight greater than typical, from Growth Chart 1 or 4)
<input type="checkbox"/> Hgb. less than 11 gm. or Hct. less than 34% (from Question 14)	<input type="checkbox"/> Short for Age (height less than typical, from Growth Chart 2 or 5)
<input type="checkbox"/> Underweight (weight less than typical, from Growth Chart 1 or 4)	<input type="checkbox"/> Wt. for Ht. (greater or less than typical, from Growth Chart 3 or 6)

COMMENTS (use additional page if needed)

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

For use with Activity 6 (& Activity 9 in Module 2). Or, use Appendix C: Blank Records & Forms to update this Handout.