

WELL CHILD EXAM-EARLY CHILDHOOD: 4 Year

DATE

PATIENT NAME				DOB		SEX		PARENT NAME			
Allergies						Current Medications					
Prenatal/Family History						Chief Complaint(s)					
Weight	Percentile	Length	Percentile	BMI	Percentile	BP	Temp.	Pulse	Resp.		
	%		%		%						

<p>Interval History: (Include injury/illness, visits to other health care providers, changes in family or home)</p> <hr/> <p>Nutrition</p> <p><input type="checkbox"/> Grains _____ servings per day</p> <p><input type="checkbox"/> Fruit/Vegetables _____ servings per day</p> <p><input type="checkbox"/> Whole Milk _____ servings per day</p> <p><input type="checkbox"/> Meat/Beans _____ servings per day</p> <p><input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water</p> <p>WIC <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Elimination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Exercise Assessment</p> <p>Physical Activity: _____ minutes per day</p> <p>Sleep</p> <p><input type="checkbox"/> Normal (8 – 12 hours) <input type="checkbox"/> Abnormal</p> <p>Additional area for comments on page 2</p> <p>Screening and Procedures:</p> <p>Hearing <input type="checkbox"/> Screening audiometry</p> <p><input type="checkbox"/> Parental observation/concerns</p> <p>Vision <input type="checkbox"/> Visual acuity</p> <p>_____ R _____ L _____ Both</p> <p><input type="checkbox"/> Parental observation/concerns</p> <p>Developmental Surveillance</p> <p><input type="checkbox"/> Social-Emotional <input type="checkbox"/> Communicative</p> <p><input type="checkbox"/> Cognitive <input type="checkbox"/> Physical Development</p> <p>Psychosocial/Behavioral Assessment</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Screening for Abuse <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>If Risk:</p> <p><input type="checkbox"/> IPPD _____ (result)</p> <p><input type="checkbox"/> Hct or Hgb _____ (result)</p> <p><input type="checkbox"/> Dyslipidemia _____ (result)</p> <p><i>If not previously tested:</i></p> <p><input type="checkbox"/> Lead level _____ mcg/dl (required for Medicaid)</p> <p><input type="checkbox"/> Labs _____</p> <p>Immunizations:</p> <p><input type="checkbox"/> Immunizations Reviewed, Given & Charted - if not given, document rationale (Refer to AAP Guidelines)</p> <p><input type="checkbox"/> Impactsis (OH registry) updated</p> <p><input type="checkbox"/> Influenza <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours</p>	<p>Patient Unclothed <input type="checkbox"/> Y <input type="checkbox"/> N</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">Review of Systems</th> <th colspan="2">Physical Exam</th> <th rowspan="2">Systems</th> </tr> <tr> <th>N</th> <th>A</th> <th>N</th> <th>A</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Appearance</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin/nodes</td></tr> <tr><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td>Extremities/hips</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neurological</td></tr> </tbody> </table> <p><input type="checkbox"/> Abnormal Findings and Comments</p> <hr/> <p>(see additional note area on next page)</p> <p>Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Plan</p> <p><input type="checkbox"/> History/Problem List/Meds Updated</p> <p><input type="checkbox"/> Referrals</p> <p style="margin-left: 20px;"><input type="checkbox"/> WIC <input type="checkbox"/> Head Start <input type="checkbox"/> Help Me Grow</p> <p style="margin-left: 20px;"><input type="checkbox"/> Children Special Health Care Needs</p> <p style="margin-left: 20px;"><input type="checkbox"/> Transportation <input type="checkbox"/> Dentist</p> <p style="margin-left: 20px;"><input type="checkbox"/> 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placed in back seat</p> <p><input type="checkbox"/> Smoke-free Home and car /smoke alarms</p> <p><input type="checkbox"/> Use bike helmet</p> <p><input type="checkbox"/> Teach stranger/pedestrian/playground safety & supervise child when outdoors</p> <p><input type="checkbox"/> Childproof home - (matches, poisons, cigarettes, cleaners, medicines, knives)</p> <p><input type="checkbox"/> Gun safety</p> <p>Nutrition/physical activity</p> <p><input type="checkbox"/> Physical activity in a safe environment</p> <p><input type="checkbox"/> Family physical activity</p> <p><input type="checkbox"/> Limit screen time to 1-2 hours per day</p> <p><input type="checkbox"/> Offer variety of healthy foods</p> <p><input type="checkbox"/> Eat meals as a family</p> <p>Child Development and Behavior</p> <p><input type="checkbox"/> Supervise tooth brushing</p> <p><input type="checkbox"/> Reinforce limits, provide choices</p> <p><input type="checkbox"/> Encourage child to talk about feelings</p> <p><input type="checkbox"/> Create a bedtime ritual that includes reading or calmly talking with your child</p> <p><input type="checkbox"/> Simple household tasks & responsibilities</p> <p><input type="checkbox"/> Praise good behavior and accomplishments</p> <p>Family Support and Relationships</p> <p><input type="checkbox"/> Use correct terms for all body parts.</p> <p><input type="checkbox"/> Explain good touch/bad touch and that certain body parts are private</p> <p><input type="checkbox"/> Listen/respect/show interest in activities</p> <p><input type="checkbox"/> Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression</p> <p><input type="checkbox"/> Discuss community programs, preschool, head start, parenting groups, after school child care</p>
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes No

- Please tell me any concerns about the way your child is behaving or developing

- My child is learning how to play and share with others.
- My child says positive things about themselves.
- My child can tell when others are happy, mad or sad.
- My child enjoys pretend play.
- My child eats a variety of foods.
- My child can sing a song.
- My child can hop on one foot.

Ask the parent to respond to the following statements:

Yes No

- I have people who assist me when I have questions or need help.
- I am enjoying my time with my child.
- I have time for myself, partner and friends.
- I feel safe with my partner.
- I feel confident in parenting.

Provider to follow up as necessary

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool. Tool Used: _____).

Child Development			Parent Development		
Dresses self	Yes	No	Appropriately disciplines child	Yes	No
Balances on each foot for 2 seconds	Yes	No	Parent is loving toward child	Yes	No
Says first and last name when asked	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Can draw a person with three parts	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Aggressive or destructive behavior that threatens, harms or damages people, animals or property	Yes	No			
Displays negativity, low self-esteem, or extreme dependence	Yes	No			

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

Your Child's Health at 4 Years

Milestones

Ways your Child is developing between 4 and 5 years of age.

- Counts on fingers and knows some letters
- Talks about what will happen tomorrow and what happened yesterday
- May begin to skip
- May have special friends and may tease or ignore some children
- Begins to know the difference between right and wrong and telling the truth and lying
- May want to be "just like you" and may want to share in the things you do
- Uses words to solve simple problems and say what they're feeling
- Plays dress-up and make believe with other children

For Help or More Information:

Safety information:

Call 1-202-662-0600 or go to www.usa.safekids.org

Car seat safety:

Contact the Auto Safety Hotline at 1-888-327-4236 or online at www.nhtsa.dot.gov

To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at www.seatcheck.org

Social Support Services: Contact the local county Department of Job and Family Services Healthchek Coordinator

For help finding childcare:

Bureau of Child Care and Development -800.886.3537
<http://www.odjfs.state.oh.us/cdc/query.asp>

For information about lead screening:

Medicaid Consumer Hotline-800.324.8680

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222

For information if you're concerned about your child's development:

Contact Help Me Grow at 1-800-755-GROW (4769) or at www.ohiohelpmegrow.org/.

Parenting skills or support:

Call Cooperative Extension for classes-614. 688.5378

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at www.ndvh.org

For help teaching your child about fire safety:

Talk with firefighters at your local fire station

Health Tips:

Your child will need some shots before starting school. Make sure you get them soon.

Be a role model for your child. Teach your child healthy habits by eating healthy foods, limiting screen time (T.V., computers, video games) and encouraging family physical activity.

Help your child get enough sleep so she will be happier and will learn easier! Put her to bed early so she gets 10 to12 hours of sleep at night. Have a bedtime routine to calm your child before going to sleep. Read a story or talk together before bed.

Each child develops in his own way, but you know your child best. If you think he is not developing well, call your child's doctor or nurse and tell them your concerns.

Parenting Tips:

Help your child know what to expect by making a calendar of pictures to show her activities for the day.

Your child learns best by doing. He needs to:

- Play active games (tag, ball, riding toys, climbing)
- Play board games and do puzzles

Limit television and computer time to 1 – 2 hours a day.

Help your child feel good about herself and others:

- Praise your child every day
- Be clear about behaviors that are okay or not okay
- Help your child use words when she is feeling upset instead of hitting, kicking, biting or saying mean things
- Talk to your child about why teasing other children is wrong and what she should do instead

If you feel very mad or frustrated with your child:

1. Make sure your child is in a safe place and walk away.
2. Call a friend to talk about what you are feeling.
3. Call Cooperative Extension for classes-614. 688.5378
4. Call 800.448.3000 or visit Boystown Parenting Hotline at (<http://www.parenting.org/hotline/index.asp>). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day.

Safety Tips

Booster car seats are for big kids! Use a booster in the back seat with lap/shoulder belts.

Make sure your child knows his address and phone number. Teach him how to call 911 in an emergency and to stay on the line if he has to call for help. Practice with a toy phone.

Teach your child to stop, drop, and roll on the ground if her clothes catch on fire.