New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
INFANCY: 2-Months

DATE: _____

Child's Name	Date of Birth
Allergies	Birth Weight

Illnesses/Injuries/Problems/Concerns	Current Medications

RN:

SUBJECTIVE

Y N

- ☐ ☐ My baby is sleeping well
- ☐ ☐ My baby is eating, sucking well
- ☐ ☐ My baby can see and hear
- ☐ ☐ My baby makes cooing sounds
- ☐ ☐ My baby lifts his/her head while on tummy
- ☐ ☐ I am concerned that I have frequent times of sadness

Diet: ☐ Breast Milk ☐ Formula

Feedings: Amount: _____ Frequency: _____

- ☐ Newborn Hearing Screening Results
- ☐ Review Immunization Record
- ☐ WIC Referral

Elimination: _____

Sleep: _____

Other: _____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

- ☐ Family Planning
- ☐ Development
- ☐ Infant Bond
- ☐ Passive Smoke
- ☐ Appropriate Car Seat
- ☐ Safety (general)
- ☐ Crib Safety
- ☐ Feeding/Colic
- ☐ No Bottle in Bed
- ☐ Sleeping on Back
- ☐ Shaken Baby Syndrome
- ☐ Fever Protocols
- ☐ Child Care Issues
- ☐ Oral Health Care
- ☐ Honey Restrictions
- ☐ Other: _____

OBJECTIVE: SCREENING

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/IN PERCENTILE:	HEAD CIR. PERCENTILE:

	N	A	
Hearing	☐	☐	_____
Vision	☐	☐	_____
Development	☐	☐	_____
Behavior	☐	☐	_____
Social/Emotional	☐	☐	_____
Gross Motor	☐	☐	_____
Fine Motor	☐	☐	_____

APN/PA/MD/DO:

SUBJECTIVE

- ☐ Review of Family History

_____
_____
_____
_____

- ☐ Review of Systems

_____
_____
_____
_____
_____

OBJECTIVE: PHYSICAL

	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head/Fontanels	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Dental Structure/Tongue	☐	☐	Neurological	☐	☐
Mental Health	☐	☐			

ASSESSMENT (Problem List)

_____
_____

PLAN

_____
_____
_____

REFERRALS

_____
_____

APN/PA/MD/DO SIGNATURE:

RN ASSESSMENT:	RN PLAN:	REFERRALS:
RN SIGNATURE:		

NEXT VISIT: 4 MONTHS OF AGE

IMMUNIZATIONS: ☐ Given ☐ Up to date

Additional notes on reverse side➔

ADDITIONAL NOTES