New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
INFANCY: 12 Months

DATE: _____

Child's Name	Date of Birth
Allergies	Birth Weight

Illnesses/Injuries/Problems/Concerns	Current Medications

RN:

SUBJECTIVE

Y	N	
☐	☐	My baby can make sounds
☐	☐	My baby pulls self to standing position
☐	☐	My baby drinks from a cup
☐	☐	My baby eats a variety of foods
☐	☐	I am concerned that I have frequent times of sadness

Diet: _____

- ☐ Vitamin Supplements
- ☐ Fluoride Supplement
- ☐ Blood Lead Screen
- ☐ Review Immunization Record
- ☐ TB Test (if high risk factor present)
- ☐ Hgb/Hct
- ☐ WIC Referral
- ☐ Dental Referral

Elimination: _____

Sleep: _____

Other: _____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

- ☐ Family Planning
- ☐ Development Benchmarks
- ☐ Crib Safety
- ☐ Fever Protocols
- ☐ Weaning
- ☐ Discipline Limits
- ☐ Child Care Issues
- ☐ Lead Poisoning Prevention
- ☐ Safety (general)
- ☐ Passive Smoke
- ☐ Appropriate Car Seat
- ☐ Feeding/Colic
- ☐ Oral Health Care
- ☐ Language Stimulation
- ☐ Bath Safety

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/Fontanel	☐	☐	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: 15 MONTHS OF AGE

IMMUNIZATIONS: ☐ Given ☐ Up to date

Additional notes on reverse side➔

ADDITIONAL NOTES