New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
CHILDHOOD: 2 Years

DATE: _____

Child's Name		Date of Birth
Allergies	Illnesses/Injuries/Problems/Concerns	Current Medications

RN:

SUBJECTIVE

Y	N	
☐	☐	My child eats a variety of foods
☐	☐	My child's night time habits concern me
☐	☐	My child can kick a ball
☐	☐	My child can stack blocks
☐	☐	My child uses 2-3 word sentences
☐	☐	My child is showing interest in toilet training

Diet: _____

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

Elimination: _____
Sleep: _____
Other: _____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

☐ Nutrition
☐ Safety (general)
☐ Car Seat or Booster Seat
☐ Development Benchmarks
☐ Bath Safety
☐ Lead Poisoning Prevention
☐ Child Care Issues
☐ Sleep Habits
☐ Other: _____
☐ Toilet Training
☐ Passive Smoke
☐ Language Development
☐ Discipline/Limits
☐ Oral Health Care
☐ Supervision
☐ TV Habits

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: 3 YEARS OF AGE

IMMUNIZATIONS: ☐ Given ☐ Up to date

Additional notes on reverse side➔

ADDITIONAL NOTES