Child's Name

Allergies

Illnesses/Injuries/Problems/Concerns

Current Medications

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

Elimination: ________________________________
Sleep: ________________________________
Other: ________________________________

**HEALTH EDUCATION/ANTICIPATORY GUIDANCE:**

- [ ] Nutrition
- [ ] Safety (general)
- [ ] Car Seat or Booster Seat
- [ ] Developmental Benchmarks
- [ ] Bath Safety
- [ ] Lead Poisoning Prevention
- [ ] Child Care Issues
- [ ] Sleep Habits
- [ ] Other: ________________________________

**OBJECTIVE: PHYSICAL**

- [ ] General Appearance
- [ ] Skin
- [ ] Head/Fontanel
- [ ] Eyes
- [ ] Ears
- [ ] Nose
- [ ] Oropharynx/Teeth
- [ ] Dental Structure/Tongue
- [ ] Abdomen
- [ ] Genitalia
- [ ] Spine
- [ ] Extremities
- [ ] Neurological
- [ ] Mental Health

**ASSESSMENT (Problem List)**

- [ ] Other: ________________________________

**OBJECTIVE: SCREENING**

- [ ] Hearing
- [ ] Vision
- [ ] Development
- [ ] Behavior
- [ ] Social/Emotional
- [ ] Gross Motor
- [ ] Fine Motor

**PLAN**

- [ ] Other: ________________________________

**REFERRALS**

- [ ] Other: ________________________________

**APN/PA/MD/DO SIGNATURE:**

**NEXT VISIT: 3 YEARS OF AGE**

**IMMUNIZATIONS:**
- [ ] Given
- [ ] Up to date

CH-21 / JUL 12 (Adapted from EPSDT form: DHS DMAHS/OQT/NJ HMOs)