COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
Please remember to have your provider fill in the Early Head Start Well Child
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238

Anticipatory Guidance for the 12 Month Well Child Physician Visit

Date_____

My toddler is _____months old. He/she weighs _____

And is _____long and has a head circumference of _____.

At this visit you can expect:

- Your toddler will be weighed and his or her length and head circumference will be measured.
- Your toddler will be undressed for a full physical exam.
- Your toddler's vision and hearing will be checked.
- Your toddler's development will be checked.
- Your toddler will have his blood checked for exposure to lead. If not provided at PCP office ask your provider for a referral.
- Your toddler may have a Tuberculin skin test.
- Your toddler will have Hematocrit/hemoglobin tested for anemia. If not provided at PCP office ask your provider for a referral.
- Your toddler's oral health will be checked.

Immunizations: Please provide Home Visitor with copies of completed immunizations and/or catch-up schedule. .Ask your provider about these:

Hepatitis B-#3 (due at age 8 months up to age 19 months)
Diphtheria, Tetanus Pertussis (DTaP)-#4 (due at age 8 months up to age 19 months)
Inactive Polio-#3 (due at age 8 months up to age 19 months)
Haemophilus influenza Type b (Hib)
Pneumococcal
Measles, Mumps and Rubella (MMR)-#1 (starting at age 12 months up to 16 months)
Varicella-#1 (starting at age 12 months up to 16 months)
Hepatitis A-#1 (starting at age 12 months up to 16 months)

You might want to discuss with your provider:

- Any illnesses your toddler has experienced, any visits to another provider and any emergency room visits.
- Your toddler's eating, sleeping and play patterns. What foods your toddler likes.
- Discipline concerns. Teaching your toddler boundaries.
- Childproofing your home.
- Family changes since your last visit.
- Oral Health Concerns: Bottle at night, "sippy" cup, juice/milk before bed, tooth-friendly snacks. Ask your provider to check your child's mouth for any cuts, sores, white spots, blisters, or swelling of the gums. Ask your provider to check for any white spots on teeth as well. If child does not have a dental home request a referral. If you have any oral health concerns ask your provider for a dental referral.

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208-736-0741

9-36 Month Nutritional Screening and Anticipatory Guidance

To be completed within 45 days of enrollment and following each age interval of: ***9, 12, 15, 18, 24, 30, and 36 months of age***

Office Use Only:	Enrollment Date:	FE Name:

Child's Name: _____

Date of Birth: _____ Parent/Guardian Names: _____

How many meals and snacks are offered to your child daily: _____ Meals _____ Snacks

Does your child:		**How often?**	**Comments**
Drink from a bottle	__ Yes __No	___times/day	_____
Drink from a cup	__ Yes __No	___times/day	_____
Take a bottle to bed	__ Yes __No	___times/day	_____

Does your child drink any of the following?

Breast milk	__Yes __ No	___times/day	_____
Formula	__Yes __ No	___times/day	type_____
Cows milk (pasteurized)	__Yes __ No	___times/day	1%,2%,whole_____
Evaporated milk	__Yes __ No	___times/day	_____
Soy or Rice Milk	__Yes __ No	___times/day	_____
Goats milk	__Yes __ No	___times/day	_____
Water	__Yes __ No	___times/day	_____
Juice	__Yes __ No	___times/day	_____
Tea	__Yes __ No	___times/day	_____
Kool-Aid/Soda	__Yes __ No	___times/day	_____
Cows milk (raw)	__Yes __ No	___times/day	_____

Does your child:		How Often?	Comments
Take vitamin or mineral supplements?	__ Yes __ No	_____times/day	_____
Take herbal supplements?	__Yes __ No	_____times/day	_____
Take iron supplements?	__Yes __ No	_____times/day	_____
Eat non-food items?	__Yes __ No	_____times/day	_____

Are there any foods your child may not eat for personal, cultural, ethnic, religious, or health reasons?
__Yes __No *If yes, which ones*? _____
If yes, Please fill out a Food Preference form

Does your child have any special food or nutritional needs? __Yes __No
If yes, please explain: _____
If yes, Please fill out a Medical Food Substitution form

Child's Favorite Foods: _____
Child's Least Favorite Foods: _____
Are there any specific foods that you would like to see at Early Head Start Family Gatherings?
_____

Is your child on WIC?	__Yes __ No
Do your food dollars meet your family need?	__Yes __ No
Does your child live in a home that has running water?	__Yes __ No
Does your child live in a home that has a working stove and refrigerator?	__Yes __ No

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DAILY NUTRITIONAL INTAKE

Please write down everything that your child ate yesterday.
Was this a typical day? __Yes __ No

Time	Food/Drink Consumed	Amount Consumed (Cups, ounces, spoon-fuls, etc.)	Notes

Do you have any concerns about your child's eating patterns? __ Yes __ No
If yes, please explain? _____
_____
_____

If yes, Please send a copy of this form to the child's Primary Medical Provider

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Staff Signature **Date**