**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 15-18 Month Well Child Physician Visit

Date_____

My toddler is _____months old.

He/she weighs _____and is _____long.

**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 may be screened for autism, be sure to ask your provider.
- Your toddler's vision and hearing will be checked.
- Your toddler's development will be checked.
- Your toddler may have a blood test for metabolic screening.
- Your toddler's oral health may be checked. If not please ask PCP to check your child's mouth. If you have any concerns ask for a dental referral.

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

Hepatitis B-#3 (starting at age 8 months up to 19 months)
Diphtheria, Tetanus Pertussis (DTaP)-#4 (starting at age 8 months up to 19 months)
Inactive Polio-#3 (starting at age 5 months up to 19 months)
Haemophilus influenza Type b (Hib)-3 doses by age 15 months
Pneumococcal-3 doses by age 18 months
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 progress in walking and talking.
- Your toddler's behavior, favorite activities and personality.
- Discipline concerns.
- Your child's eating and sleeping patterns.
- Family changes since your last visit.
- Ask your provider to check your child's mouth for any cuts, sores, white spots, blisters of swelling of the gums. Ask provider to check for any white spots on teeth as well. If child does not have a dental home re quest a referral. If you have any oral health concerns ask your provider for a dental referral.
- Developmental Milestones: See CDC Chart.

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## 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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## 9-36 Month Nutritional Screening and Anticipatory Guidance

*To be conducted at 9, 12, 15, 18, 24, 30, and 36 months of age*

# DAILY NUTRITIONAL INTAKE

Please write down everything that your child ate yesterday.

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

**Was this a typical day? __Yes __ No**
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**