

Anticipatory Guidance for the 36 Month Well Child Physician Visit

Date _____

My child is _____ months old.

He/she weights _____ and is _____ long.

At this visit you can expect:

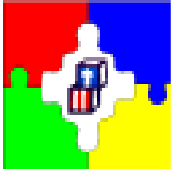
- Your child's weight and height (Body Mass Index) will be measured.
- Your child will be undressed for a full physical exam.
- Your child's vision and hearing will be checked.
- Your child's development will be checked.
- Ask your provider if your child needs to catch up on any immunizations.
- Your child may have Hematocrit/hemoglobin tested for anemia. If not, ask provider for a referral.
- Your child may have a Tuberculin skin test.
- Your provider may ask about your child's last dental cleaning and exam. Ask provider to check your child's mouth. If there are any concerns request a dental referral.

Immunizations: Please provide Home Visitor with copies of completed immunizations and/or catch-up schedule. Your child should have the following number of vaccines unless on a catch-up schedule:

- Hepatitis B-3 doses
- Diphtheria, Tetanus Pertussis (DTaP)-4 doses
- Inactive Polio-3 doses
- Rotavirus- 3 doses (cannot get past 8 months of age)
- Haemophilus influenza Type b (Hib)-3 doses
- Pneumococcal-3 doses
- Measles, Mumps and Rubella (MMR)-1 dose
- Varicella-1 dose
- Hepatitis A-2 doses

You might want to discuss with your provider:

- Any illnesses your toddler has experienced, visits to another provider, and any emergency or side visits.
- Your child's ability to feed and dress him/herself, other self-help skills.
- Your child's communication (new words and phrases). His ability to follow instructions.
- Toilet training concerns.
- Appropriate discipline.
- Things your child enjoys.
- Family changes since your last visit.
- Ask your provider to check your child's mouth for any cuts, sores, white spots, blisters or swelling of the gums. Ask provider to check for any white spots on teeth as well. If child does not have a dental home request a referral.
- Developmental Milestones: See CDC Chart
- Pre-School Readiness.



COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START

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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:
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Drink from a cup <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take a bottle to bed <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____

Does your child drink any of the following?

Breast milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Formula	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	type _____
Cows milk (pasteurized)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	1%,2%,whole _____
Evaporated milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Soy or Rice Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Goats milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Water	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Tea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Kool-Aid/Soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Cows milk (raw)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____

Does your child:	How Often?	Comments
Take vitamin or mineral supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Eat non-food items? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

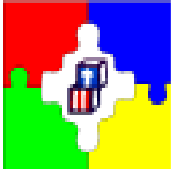
Are there any specific foods that you would like to see at Early Head Start Family Gatherings?

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