# 6–10 Years

## Department of State Health Services
## Child Health Record
## Preventive Health Visit

### Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

### Family Profile and Health

_____No change in household since last visit
Child lives with:
_____Mother ____ Father ____ Stepparent _____Grandparent
_____Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

### Mental Health

(+ indicates need for futher assessment)

____Sleep Problems
____Behavior/problems
____Relationship problems with parents, siblings, peers
____Problems in school
Grade Level_____
____Special education classes
____No/excessive extracurricular activities
____Substance abuse/use
____Self-concept problems

Comments:

### Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y. _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Dental Care/sealants:

### Physical Examination

Temp_____ Pulse _____Resp _____
BP_____ Height _____Weight_____
(%)_____ (%) _____(%)_____

| | N | A | NE |
|---|---|---|---|
| Appearance | | | |
| Head/fontanels | | | |
| Skin/nodes | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Mouth/throat | | | |
| Teeth | | | |
| Neck | | | |
| Chest/breasts (Tanner stage) | | | |

| | N | A | NE |
|---|---|---|---|
| Heart/pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia/anus (Tanner stage) | | | |
| Spine | | | |
| Extremities | | | |
| **Neurologic:** | | | |
| Muscle tone | | | |
| DTRs | | | |

Additional documentation:

### Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group* _____Y _____N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
____Dairy ____Vegetables ___ Fruits
____Breads, cereal, rice, and pasta
____Meat, poultry, fish, eggs, and dry beans

### Sensory

Vision Screen: _____Normal ____ Abnormal
Hearing Screen: _____Normal ____ Abnormal
Screen used: _____Hearing Checklist for Parents

### Health Education

**Injury Prevention**
____Seat belt/auto safety
____Bicycles/ATV
____Athletics
____Water safety
____Smoke detectors
____Firearm safety

**Behavior**
____Substance abuse
____Tobacco use
____Security
____Discipline patterns
____Responsibility
____Communication/conflict resolution

**Health Promotion**
____Limit TV viewing
____Passive smoking
____Regular exercise
____Pubertal changes/sexuality
____Dental care/sealants

**Nutrition**
____Healthy diet/snacks
____Junk food
____Iron-rich foods

### Assessment

### Plan

Dental referral made: ___Y ___N
Immunizations: ___Up to date ___To be given today ___Deferred
Explain:
Lab:
Hct/Hgb _____ Lead_____
Next appointment:

Date: _____Signature/Title: _____Signature/Title_____

# C.55 TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

| Place a mark in the appropriate box: | Yes | No | Don't Know |
|---|---|---|---|
| TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:<br>has your child been around anyone with any of these symptoms or problems? or<br>has your child had any of these symptoms or problems? or<br>has your child been around anyone sick with TB? | | | |
| Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia? | | | |
| Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?<br>If so, specify which country/countries? | | | |
| To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country? | | | |

Has your child been tested for TB? Yes___ (if yes, specify date ___/___) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ___/___) No___

For school/healthcare provider use only

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PPD administered Yes___ No___

If yes,

Date administered ___/___/___ Date read ___/___/___ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____

signature printed name

Provider phone number _____

City _____ County _____

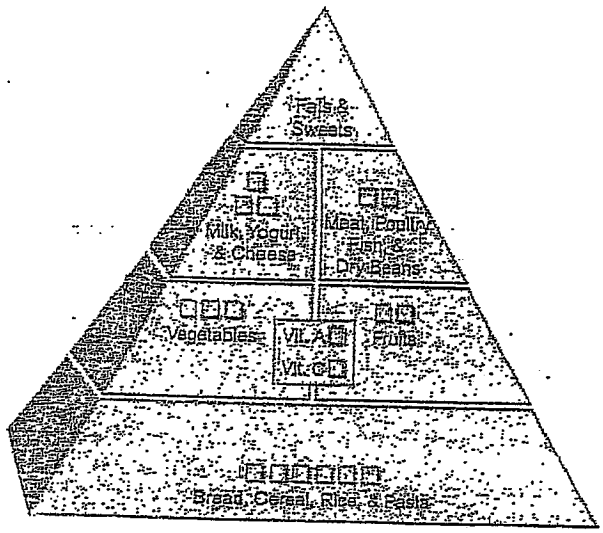
If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

**Nutrition Education**

- ☐ physical activity
- ☐ iron-rich foods
- ☐ GI disturbances or problems with milk
- ☐ weight management
- ☐ healthy diet
- ☐ other: _____
- ☐ healthy snacks
- ☐ dental health
- ☐ low-fat eating for heart health
- ☐ inadequate/excessive intake of: _____

Date: _____ Counseled by: _____




Minimum Servings

| List all foods and beverages consumed in the past 24 hours or previous day. | Amount Consumed |
|---|---|
| | |

# C.12 24-Hour Dietary Recall and Assessment for Children (5–9 Years) (2 Pages)

## 24-Hour Dietary Recall and Assessment for Children 5 Through 9 Years

Name _____
DOB _____ Age _____
SSN/Record No. _____
Required for Child Health

**Medical Risks**

*Is child underweight or overweight, or does child have poor growth? _____ ☐ Yes ☐ No
If yes, list: _____
*Does child have anemia? _____ ☐ Yes ☐ No
*Does child have lead poisoning? _____ ☐ Yes ☐ No
*Does child have chronic vomiting, diarrhea, or constipation? _____ ☐ Yes ☐ No
If yes, list: _____

**Resources**

Working stove and refrigerator? _____ ☐ Yes ☐ No
☐ School breakfast ☐ Food Stamps
☐ School lunch ☐ Food pantry or soup kitchen
☐ Summer food program
Do you need help in obtaining food? _____ ☐ Yes ☐ No

**Dietary Practices**

*Is child on a therapeutic or special diet? _____ ☐ Yes ☐ No
If yes, describe: _____
GI problems with milk products? _____ Prescribed by: _____
*Any major food allergies? _____ ☐ Yes ☐ No
If yes, list: _____ Symptoms: _____
*Any food groups refused? _____ ☐ Yes ☐ No
If yes, list: _____
Does child or family eat or avoid any special foods for religious or health reasons? _____ ☐ Yes ☐ No
If yes, describe: _____

**Health Habits**

Hours of TV per day: _____
How many minutes per day is child physically active? _____
What type of activity? _____
How many meals given daily? _____
Are meals eaten with family? _____
Are snacks given? _____ ☐ Yes ☐ No
If yes, list: _____ ☐ Yes ☐ No
How many snacks per day? _____
How often are the child's teeth brushed and flossed? _____
Encouraged to clean plate? _____
Vitamin/mineral pills? _____ ☐ Yes ☐ No
If yes, list brand or type: _____ ☐ Yes ☐ No

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: _____
Recall assessed by: _____ Date: _____

STUDENT'S NAME: _____ BIRTHDATE: _____
SCHOOL: _____ GRADE: ____ TEACHER: _____

**THE INFORMATION ENTERED ON THIS FORM IS A RECORD OF SCREENING RESULTS AND IS NOT TO BE USED FOR DIAGNOSTIC PURPOSES.**

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## SWEEP-CHECK SCREENING

1. Instruct and condition each child appropriately for age/grade.
2. Screen 3 frequencies @ **25 dB;** begin screening @ 1000 Hz.
3. Identify responses with a "+"; identifying no response with a "-".
4. Sequence of tone presentations is numbered 1-3 below.

| | EAR | 1<br>1000 Hz | 2<br>2000 Hz | 3<br>4000 Hz | RESULTS |
|---|---|---|---|---|---|
| First Screen | R | | | | _____ Pass |
| Date: | L | | | | _____ Rescreen w/Sweep |

COMMENTS: _____

Screener: _____

Children failing to respond to **ONE** (of the three) frequencies in **EITHER EAR** should be re-screened with another Sweep-Check within 3 to 4 weeks. (Signs or symptoms alone would be sufficient for referral.) Failure of **ONE** frequency in either ear on the second sweep check screen requires a referral or an **Extended Recheck.** If a failure of one frequency occurs when performing the extended recheck, a referral is required.

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| | EAR | 1<br>1000 Hz | 2<br>2000 Hz | 3<br>4000 Hz | RESULTS |
|---|---|---|---|---|---|
| Second Screen | R | | | | _____ Pass |
| Date: | L | | | | _____ Fail |

COMMENTS: _____

Screener: _____

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## EXTENDED RECHECK RESULTS

For each of the three frequencies listed, starting at **40 dB,** record the lowest level in decibels (dB) at which the child responds. Record the findings for both the right and left ears. A child should be referred to an appropriately licensed professional if any one of the three frequencies are recorded as greater than **25 dB** in either ear.

| | EAR | 1<br>1000 Hz | 2<br>2000 Hz | 3<br>4000 Hz | RESULTS |
|---|---|---|---|---|---|
| | R | dB | dB | dB | _____ Pass |
| Date: | L | dB | dB | dB | _____ Fail |

COMMENTS: _____

Screener: _____

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

# Screening Questionnaire for Child and Teen Immunization

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Is the child sick today? | ☐ | ☐ | ☐ |
| 2. Does the child have allergies to medications, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| 3. Has the child had a serious reaction to a vaccine in the past? | ☐ | ☐ | ☐ |
| 4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? | ☐ | ☐ | ☐ |
| 5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| 6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? | ☐ | ☐ | ☐ |
| 7. Does the child have cancer, leukemia, AIDS, or any other immune system problem? | ☐ | ☐ | ☐ |
| 8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? | ☐ | ☐ | ☐ |
| 9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| 10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | ☐ | ☐ | ☐ |
| 11. Has the child received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

**Did you bring your child's immunization record card with you?** **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/11)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

# Information for Health Professionals about the Screening Questionnaire for Child & Teen Immunization

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

**1. Is the child sick today?** *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

**2. Does the child have allergies to medications, food, a vaccine component, or latex?** *[all vaccines]*
If a person reports they have an allergy to egg, ask if they can eat lightly cooked eggs (e.g., scrambled eggs). If they can, trivalent influenza vaccine (TIV) may be admininistered. If after eating eggs or egg-containing foods, they have a reaction consisting of only hives, TIV may be given and the person should be observed for at least 30 minutes. If a person experiences a serious systemic or anaphylactic reaction (e.g., hives and either swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs, do not administer TIV or live attenuated influenza vaccine (LAIV). It is possible that they may be eligible to be given TIV, but only after they have seen a physician with expertise in the management of allergic conditions. If a person has anaphylaxis after eating gelatin, do not administer measles-mumps-rubella (MMR), MMR+varicella (MMRV), or varicella vaccine. A local reaction is not a contraindication. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive table of vaccine components, see reference 3.

**3. Has the child had a serious reaction to a vaccine in the past?**
*[all vaccines]* History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

**4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?** *[LAIV]*
Children with any of the health conditions listed above should not be given the intranasal, live attenuated influenza vaccine (LAIV). These children should be vaccinated with the injectable influenza vaccine.

**5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?** *[LAIV]*
Children who have had a wheezing episode within the past 12 months should not be given the live attenuated influenza vaccine. Instead, these children should be given the inactivated influenza vaccine.

**6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem?** *[DTaP, Td, Tdap, TIV, LAIV, MMRV]* DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap, and a progressive neurologic disorder in a teen is a precaution to the use of Td. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (*exception:* children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with TIV if at high risk for severe influenza complications.

**7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?** *[LAIV, MMR, MMRV, RV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, rotavirus, and the intranasal live, attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. For details, consult the ACIP recommendations (4, 5, 6).

**8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?** *[LAIV, MMR, MMRV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant individuals age 2–49 years.

**9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?** *[LAIV, MMR, MMRV, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current *Red Book* for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

**10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?** *[LAIV, MMR, MMRV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 6). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (5, 8). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (9).

**11. Has the child received vaccinations in the past 4 weeks?**
*[LAIV, MMR, MMRV, VAR, yellow fever]*
If the child was given either live, attenuated influenza vaccine (LAIV) or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.


References:
1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. AAP. *Red Book: Report of the Committee on Infectious Diseases* at www.aapredbook.org.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. CDC. Prevention and Control of Influenza—Recommendations of ACIP at www.cdc.gov/flu/professionals/vaccination/.
7. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients, *MMWR* 2000; 49 (RR-10), www.cdc.gov/vaccines/pubs/down-loads/b_hsct-recs.pdf.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).