

WELL CHILD EXAM-EARLY CHILDHOOD: 3 Year

DATE _____

PATIENT NAME			DOB		SEX		PARENT NAME		
Allergies					Current Medications				
Prenatal/Family History					Chief Complaint(s)				
Weight	Percentile	Length	Percentile	BMI	Percentile	BP	Temp.	Pulse	Resp.
	%		%		%				

Interval History:
(Include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

Grains _____ servings per day

Fruit/Vegetables _____ servings per day

Whole Milk _____ servings per day

Meat/Beans _____ servings per day

City water Well water Bottled water

WIC Y N

Elimination Normal Abnormal

Exercise Assessment

Physical Activity: _____ minutes per day

Sleep

Normal (8 – 12 hours) Abnormal

Additional area for comments on page 2

Screening and Procedures:

Oral Health Risk Assessment

Subjective Hearing -Parental observation/ concerns

Vision Visual acuity

_____ R _____ L _____ Both

Parental observation/concerns

Developmental Surveillance

Social-Emotional Communicative

Cognitive Physical Development

Psychosocial/Behavioral Assessment

Y N

Screening for Abuse Y N

If Risk: IPPD _____ (result)

Hct or Hgb _____ (result)

If not previously tested:

Lead level _____ mcg/dl (required for Medicaid)

Labs _____

Immunizations:

Immunizations Reviewed, Given & Charted
- *if not given, document rationale (Refer to AAP Guidelines)*

Impactsiis (OH registry) updated

Influenza Other _____

Acetaminophen _____ mg. q. 4 hours

Patient Unclothed Y N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Abnormal Findings and Comments

(see additional note area on next page)

Results of visit discussed with parent Y N

Plan

History/Problem List/Meds Updated

Referrals

WIC Head Start`

Children Special Health Care Needs

Transportation Dentist

Other _____

Other _____

Anticipatory Guidance/Health Education
(√ if discussed)

Safety

Teach child to wash hands, wipe nose w/tissue

Reinforce bedtime routine

Fires/Burns/test smoke alarms

Appropriate car seat placed in back seat

Use bike helmet

Teach stranger safety

Childproof home - (matches, guns, medicines)

Supervise play, ensure playground safety

Nutrition/physical activity

Physical activity in a safe environment

Family physical activity

Limit screen time to 1-2 hours per day

Offer variety of healthy foods

Oral Health

Schedule dental appointment

Teach child to brush teeth

Child Development and Behavior

Reinforce limits, provide choices

Encourage talking and reading

Encourage safe exploration

Help child cope with fears

Family Support and Relationships

Show affection, spend time with each child

Create family time together

Praise good behavior and accomplishments

Substance Abuse, Child Abuse, Domestic Violence Prevention

Handle anger constructively, help siblings resolve conflicts

Make time for self, partner, friends

Choose responsible caregivers

Discuss community programs, preschool, head start, parenting groups

Next Well Check: 4 years of age

Developmental Questions and Observations on Page 2

Provider Signature: _____

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DATE	PATIENT NAME	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes No

- Please tell me any concerns about the way your child is behaving or developing

- My child is able to play by him/herself for short periods of time.
- My child is able to leave me when in a known place.
- My child enjoys playing with other children.
- My child can tell when others are happy, mad or sad.
- My child can copy a circle.
- My child eats a variety of foods.
- My child knows his/her name, age and sex.
- My child can jump off a step with both feet.

Ask the parent to respond to the following statements:

Yes No

- I have people who assist me when I have questions or need help.
- I am enjoying my time with my child.
- I have time for myself, partner and friends.
- I feel safe with my partner.
- I feel confident in parenting.

Provider to follow up as necessary

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool. Tool Used: _____).

Child Development			Parent Development		
Dresses self	Yes	No	Appropriately disciplines child	Yes	No
Rides a tricycle	Yes	No	Parent is loving toward Child.	Yes	No
Is understandable to others 75% of the time	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Shows preference for parent or caregiver	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Seeks comfort from parent when upset	Yes	No			

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

Your Child's Health at 3 Years

Milestones

Ways your child is developing between 3 and 4 years of age.

- Can sing a song from memory
- Learning to share
- Talks about what he did during the day
- Enjoys playing "pretend" and listening to stories
- Can hop, jump on one foot
- Rides a tricycle or a bicycle with training wheels
- Knows her first and last name
- Names 4 colors
- Begins to test limits
- Shows a silly sense of humor
- Throws a ball overhand
- Plays board games or card games
- Draws a person with 3 parts (such as head, body, legs)
- Builds towers of 9-10 blocks

For Help or More Information:

Safe Gun Storage Information:

Call 1-202-662-0600 or go to www.usa.safekids.org

For help finding childcare:

Bureau of Child Care and Development -800.886.3537

<http://www.odjfs.state.oh.us/cdc/query.asp>

Car seat safety:

Contact the Auto Safety Hotline at 1-888-327-4236 or online at www.nhtsa.dot.gov

For information about lead screening:

Medicaid Consumer Hotline-800.324.8680

Social Support Services: Contact the local county Department of Job and Family Services Healthchek Coordinator

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222

For information if you're concerned about your child's development:

Contact Help Me Grow at 1-800-755-GROW (4769) or at www.ohiohelpmegrow.org/.

Parenting skills or support:

Call Cooperative Extension for classes-614. 688.5378

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at www.ndvh.org

Health Tips:

Your child still needs about two cups of milk every day. Offer a variety of fruits and vegetables daily. Water is a healthy drink so offer it instead of sweetened drinks.

Help your child brush his teeth every day with a pea-sized amount of fluoride toothpaste. Make sure he gets a dental checkup once a year.

Teach your child to wash her hands well after playing, after using the toilet, and before eating. Use soap and rub hands together for about 20 seconds.

Each child develops in his own way, but you know your child best. If you think he is not developing well, call your child's doctor or nurse and tell them your concerns.

Parenting Tips:

Your child learns best by doing. She needs to:

- Play active games (tag, ball, riding wheeled toys, climbing)
- Play imagination games (using dolls, toys, story books)
- Play with toys that uses her hands (blocks, big puzzles)
- Limit television and computer time to 1-2 hours a day

Help your child feel good about himself and others:

- Praise your child every day
- Be consistent and clear about your child's behaviors that are okay or not okay
- Use discipline to teach and protect your child, not to punish him or make him feel bad about himself
- Help your child "use his words" when having a disagreement instead of hitting, kicking, or biting

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Put your child in a safe place and walk away.
2. Call a friend or your partner. It can help to talk about what you are feeling.
3. Call Cooperative Extension for classes-614. 688.5378
4. Call 800.448.3000 or visit Boystown Parenting Hotline at (<http://www.parenting.org/hotline/index.asp>). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day.

Safety Tips

Check your home for dangers often. Your child is not old enough to stay away from things that could harm her, like matches, guns, and poisons. Lock those things up!

Continue using a car seat until your child weighs 40 pounds or around age 4. After that, use a booster seat until your child is 4'9" or age 8. Keep your child in the back seat.

Make sure your child uses a helmet whenever he rides a tricycle, scooter, or other toys with wheels.