

# WELL CHILD EXAM-EARLY CHILDHOOD: 5 Year

DATE

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

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

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**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

**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:**

Urinalysis (Required for Medicaid)

**Hearing**  Screening audiometry

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)

Impactsis (OH registry) updated

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**

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( see additional note area on next page)

Results of visit discussed with child/parent

Y  N

**Plan**

History/Problem List/Meds Updated

Referrals

Children Special Health Care Needs

Transportation  Help Me Grow

Dentist

Other \_\_\_\_\_

Other \_\_\_\_\_

**Anticipatory Guidance/Health Education**  
(√ if discussed)

**Safety**

Teach child to wash hands, wipe nose w/tissue

Working smoke detectors/fire escape plan

Appropriate booster seat placed in back seat

Carbon monoxide detectors/alarms

Pool/tub/water safety – swimming lessons

Use bike/skating helmet

Supervise near pets, mowers, driveways, streets

Gun safety

Childproof home - (matches, poisons, cigarettes, cleaners, medicines, knives)

**Nutrition/physical activity**

Provide a healthy breakfast every morning

Family meals

Offer variety of healthy foods and include 5 servings of fruits & veggies every day

Limit TV, video, and computer games

Physical activity & adequate sleep

**Oral Health**

Schedule dental appointment

Supervise tooth brushing

Discuss flossing, fluoride, sealants

**Child Development and Behavior**

Establish routines and traditions

Explain good touch/bad touch and that certain body parts are private

Reinforce limits, provide choices

Simple household tasks & responsibilities

Praise good behavior and actions

Family Rules/Respect/Right from wrong

Encourage expression of feelings

**Family Support and Relationships**

Listen/respect/show interest in activities

Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

Discuss community and recreational programs, school, and after school care

Volunteer and become involved with school

Meet your child's school teachers

Next Well Check: 6 years of age  
Developmental Questions and Observations  
on Page 2

**Provider Signature:**

# WELL CHILD EXAM-EARLY CHILDHOOD: 5 Years

|      |              |     |
|------|--------------|-----|
| DATE | PATIENT NAME | DOB |
|------|--------------|-----|

## 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 does what I ask them to do most of the time.
- My child says positive things about themselves.
- My child shows an ability to understand the feelings of others.
- My child can tell a story using full sentences.
- My child follows simple directions.
- My child can recognize most letters and is able to print some letters.
- My child can balance on one foot.

Ask the parent to respond to the following statements:

Yes    No

- I have people I can turn to when I have questions or need help.
- I feel good about my child starting school.
- I am sad more often than I am happy.
- 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 without supervision  | Yes | No | Appropriately disciplines child   | Yes | No |
| Skips and hops   | Yes | No | Parent is loving toward child   | Yes | No |
| Draws a person with head, body, arms and legs  | Yes | No | Positively talks, listens, and responds to child.                                   | Yes | No |
| Appears unusually fearful, anxious or withdrawn  | Yes | No | Parent uses words to tell child what is coming next                                 | Yes | No |
| Aggressive or destructive behavior that threatens harms or damages people, animals or property | Yes | No | Parent encourages child to speak for him or her self, share ideas, wants and needs. | Yes | No |
| Displays negativity, low self-esteem, or extreme dependence                                    | 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:**

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Staff Signature: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

## Your Child's Health at 5 Years

### Milestones

Ways your child is developing between 5 and 6 years of age.

- Recognizes her own printed name
- May form special groups of friends and may be jealous of others
- Takes turns
- Feels proud of himself and his accomplishments
- Helps with family chores
- Able to follow rules at home and school and respect authority
- Beginning to learn rules for simple games
- Riding a bicycle and learning to swim

### For Help or More Information:

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

### **Child sexual abuse, physical abuse, information and support:**

- Childhelp National Child Abuse Hotline 1-800-4-A-CHILD (1-800-422-4453) or online at [www.childhelp.org](http://www.childhelp.org)

### **Domestic Violence hotline:**

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at [www.ndvh.org](http://www.ndvh.org)

### **Safe Gun Storage Information:**

Call 1-202-662-0600 or go to [www.safekids.org](http://www.safekids.org).

### **Poison Prevention:**

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

### **Parenting skills or support:**

Call Cooperative Extension for classes-614. 688.5378

### **For help teaching your child about fire safety:**

Talk with firefighters at your local fire station

### Health Tips:

Continue to take your child for a check-up each year with a doctor or nurse.

Your child will still need you to help get all of her teeth brushed well. Make sure to take her for a dental check-up at least once a year.

### Parenting Tips:

Eat together as often as possible. Turn off the TV and the phone, and enjoy each other.

Listen when your child talks to you. Look at him and pay attention. Then answer or ask about his ideas. Let him know that what he thinks and says is important to you.

Talk with your child about how to avoid sexual abuse. Teach your child about privacy and teach that adults shouldn't ask her to keep secrets from you or show their private parts or ask to see your child's private parts. Tell your child she should say "no" and that she should tell you if anyone tries to harm her.

Limit TV or computer time so your child also has time for books and active play. Read storybooks with him daily. Take your child outside often to play.

Help your child feel good about herself and others:

- Praise your child every day
- Be clear about behaviors that are okay or not okay
- Help your child use words when she is feeling upset instead of hitting, kicking, biting or saying mean things
- Talk to your child about why teasing other children is wrong and what she should do instead

If you feel very mad or frustrated with your child:

1. Make sure your child is in a safe place and walk away.
2. Call a friend 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

Booster car seats are for big kids! Use a booster in the back seat with lap/shoulder belts.

Your child should always wear a lifejacket around water, even after he has learned to swim.

Always watch your child closely when she is near the street. Children are not ready to ride bikes safely on streets or cross streets without an adult until they reach at least age 9. Your child is not old enough to always behave safely around vehicles.

Teach your child to never touch a gun. If he finds one, he should tell an adult right away. Make sure any guns in your home are unloaded and locked up.