


CHILD HEALTH RECORD (18-30 MONTHS)

Name: _____ DOB: _____ Age: _____ Sex: _____
Allergies: _____ Major Illness: _____
Medication taken regularly _____
Able to participate in center activities Yes No If not, why? _____

DEVELOPMENT 18 MONTHS				DEVELOPMENT 24 MONTHS				DEVELOPMENT 30 MONTHS			
<input type="checkbox"/> Drinks from a cup				<input type="checkbox"/> Uses spoon				<input type="checkbox"/> Begin Self-dressing with T-shirt			
<input type="checkbox"/> Responds to "give me"				<input type="checkbox"/> Builds tower of 2 cubes				<input type="checkbox"/> Child will imitate words			
<input type="checkbox"/> Says six words				<input type="checkbox"/> Combines 2 words				<input type="checkbox"/> Use of No for expression			
<input type="checkbox"/> Asks for familiar toys not around				<input type="checkbox"/> Follow 2-part directions				<input type="checkbox"/> Can answer the telephone			
Results	Dates	Initials		Results	Dates	Initials		Results	Dates	Initials	
Ht.inches				Ht.inches				Ht.inches			
Wt. lbs				Wt. lbs				Wt lbs			
Ht.2 (N)				Ht.2 (N)				Ht.2 (N)			
Wt.2 (N)				Wt.2 (N)				Wt.2 (N)			
B/P				B/P				B/P			
Hct.				Hct.				Hct.			
Strab.				Strab.				Strab.			
Vis. R				Vis. R				Vis. R			
Vis. L				Vis. L				Vis. L			
PT/ R				PT/ R				PT/ R			
PT/L				PT/L				PT/L			
Imp. R				Imp. R				Imp. R			
Imp. L				Imp. L				Imp. L			
Lead				Lead				Lead			
H/LDL				H/LDL				H/LDL			
Chol. T.				Chol. T.				Chol. T.			
GLU				GLU				GLU			
TB				TB				TB			
Screening Completion Date				Screening Completion Date				Screening Completion Date			
Rescreen:				Rescreen:				Rescreen:			
PHYSICAL EXAMINATION				PHYSICAL EXAMINATION				PHYSICAL EXAMINATION			
N	A	N	E	N	A	N	E	N	A	N	E
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, Mouth Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, Mouth Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, Mouth Pharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes (funduscope)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes (funduscope)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes (funduscope)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears (tympanic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears (tympanic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears (tympanic)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest/Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest/Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest/Heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glands (thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glands (thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glands (thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coordination
ASSESSMENT				ASSESSMENT				ASSESSMENT			
PLAN				PLAN				PLAN			
Entry Date:				Re/Entry Date:				Re/Entry Date:			
Date:				Date:				Date:			
Provider				Provider				Provider			