Anticipatory Guidance for the 24 Month Well Child Physician Visit

Date__________________

My child is ________________ months old.

He/she weighs _______________ and is _______________ long.

At this visit you can expect:

- Your child’s weight and height (Body Mass Index) will be measured as well as head circumference.
- 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.
- Your child may have his or her blood checked for anemia. If not, ask provider for a referral.
- Your child may have a urine analysis.
- Your child may have a Tuberculin skin test.
- Your child will receive a lead screening.
- Your child may be screened for autism.
- Your child’s oral health may be assessed.

Immunizations: Please provide Home Visitor with copies of completed immunizations and/or catch-up schedule. Ask your provider about these:

- Hepatitis A-#2 (due from 22 to 24 months)

By 24 months of age, 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 child has experienced, any visits to another provider and any emergency room visits.
- Your child’s eating and sleeping patterns.
- Your child’s communication and frustrations/ tantrums that come from not feeling understood.
- Appropriate discipline
- Toilet training concerns.
- 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 of 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. If you have any oral health concerns ask your provider for a dental referral.
- Developmental Milestones: See CDC Chart.

H-WCE-EHSFORM-24 Month Well Child Anticipatory Guidance
**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_

<table>
<thead>
<tr>
<th>Office Use Only:</th>
<th>Enrollment Date:</th>
<th>FE Name:</th>
</tr>
</thead>
</table>

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?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>times/day</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink from a bottle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drink from a cup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take a bottle to bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child drink any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>times/day</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cows milk (pasteurized)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaporated milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy or Rice Milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goats milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kool-Aid/Soda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cows milk (raw)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child: __Yes __No __times/day  __________

Take vitamin or mineral supplements? __Yes __No __times/day  __________
Take herbal supplements? __Yes __No __times/day  __________
Take iron supplements? __Yes __No __times/day  __________
Eat non-food items? __Yes __No __times/day  __________

Are there any foods your child may not eat for personal, cultural, ethnic, religious, or health reasons? __Yes __No 

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
9-36 Month Nutritional Screening and Anticipatory Guidance
To be conducted at 9, 12, 15, 18, 24, 30, and 36 months of age

**DAILY NUTRITIONAL INTAKE**

Please write down everything that your child ate yesterday.
Was this a typical day?  __Yes  __No

<table>
<thead>
<tr>
<th>Time</th>
<th>Food/Drink Consumed</th>
<th>Amount Consumed (Cups, ounces, spoonfuls, etc.)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>