Anticipatory Guidance for the 9 Month Well Child Physician Visit

Date_______________

My baby is ________________ weeks old. He/she weighs _______________
And is __________________ long and has a head circumference of _____________.

At this visit you can expect:
- Your baby will be weighed and his or her length and head circumference will be measured.
- Your baby will be undressed for a full physical exam.
- Your baby’s vision and hearing will be checked.
- Your baby’s development will be checked.
- Your baby may have his or her blood checked for exposure to lead.
- Your baby may have a Hematocrit/hemoglobin tested for anemia.

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

- Hepatitis B-#3 (due at age 8 months up to 19 months)
- Diphtheria, Tetanus Pertussis (DTaP)-#4 (due at age 8 months up to age 19 months)
- Inactive Polio -#3 (due at age 8 months up to age 19 months )
- Haemophilus influenza Type b (Hib)-#3 or 4
- Pneumococcal-#4

You might want to discuss with your provider:
- Any illnesses your baby has experienced, any visits to another provider and any emergency room or side visits.
- Observations you have made about your baby’s development and increasing independence.
- Teething concerns. Teaching your baby how to drink form a cup. Ask your provider to check your child’s mouth for any cuts, sores, white spots, blisters of swelling of the gums. If teeth have erupted ask provider to check for white spots or cavities on teeth. If you have any concerns ask provider for a dental referral.
- Childproofing your home.
- Family changes since your last visit.
- How feeding is going. How to know when your baby is developmentally ready for additional foods. How recognize reactions to foods. What foods baby likes.
- Developmental Milestones: See CDC Chart.
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

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>How often?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink from a bottle</td>
<td>__ Yes __ No</td>
<td>times/day</td>
</tr>
<tr>
<td>Drink from a cup</td>
<td>__ Yes __ No</td>
<td>times/day</td>
</tr>
<tr>
<td>Take a bottle to bed</td>
<td>__ Yes __ No</td>
<td>times/day</td>
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Does your child drink any of the following?

- Breast milk __ Yes __ No times/day type __________________
- Formula __ Yes __ No times/day __________________
- Cows milk (pasteurized) __ Yes __ No times/day 1%,2%,whole____
- Evaporated milk __ Yes __ No times/day __________________
- Soy or Rice Milk __ Yes __ No times/day __________________
- Goats milk __ Yes __ No times/day __________________
- Water __ Yes __ No times/day __________________
- Juice __ Yes __ No times/day __________________
- Tea __ Yes __ No times/day __________________
- Kool-Aid/Soda __ Yes __ No times/day __________________
- Cows milk (raw) __ Yes __ No times/day __________________

Does your child:

- 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, which ones? ______________________________________________

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>
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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

Parent/Guardian Signature ___________________________ Date __________

Staff Signature ___________________________ Date __________