1 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab
Accompanied by:		Allergies: ☐ NKA _____			Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ: ☐	Percentile: ☐

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: _____ Formula (type): _____

Developmental Screen: Age Appropriate? (e.g., responds to sounds, responds to parent's voice, follows with eyes?) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) _____ Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS:

Was Hepatitis B given at birth? Yes _____ No _____

Shot Record initiated? Yes _____ No _____

ANTICIPATORY GUIDANCE

- ☐ **Breastfeeding/Formula exclusive**
- ☐ Early dental decay
- ☐ Supine sleep position
- ☐ Injury prevention/"Baby-proofing"
- ☐ Safety with siblings and pets
- ☐ Drowning prevention/ **Sun safety**
- ☐ Car seat/Auto safety
- ☐ **"Shaken baby syndrome"**
- ☐ Signs of illness
- ☐ Temp. taking, when to call Dr.
- ☐ Emergency/911
- ☐ Passive smoke
- ☐ Parenting practices
- ☐ "Safe at home"
- ☐ Potential for abuse
- ☐ **Child care safety**
- ☐ **Limit TV/Video exposure**
- ☐ Postpartum adjustment
- ☐ Family involvement
- ☐ **Parent/Infant attachment**
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Birth to Three** ☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age

2 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA _____	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:
Pulse:
Resp:

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: _____ Formula (type): _____

Developmental Screen: Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) _____ Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ___ **Deferred?** ___

Given today? Hep B ___ **DTaP** ___ **IPV** ___ **Hib** ___ **PCV** ___ **Other** ___

ANTICIPATORY GUIDANCE

- ☐ Breastfeeding/Formula exclusive
- ☐ Early dental decay
- ☐ Supine sleep position
- ☐ Injury prevention/"Baby-proofing"
- ☐ Safety with siblings and pets
- ☐ Drowning prevention/ **Sun safety**
- ☐ Car seat/Auto safety
- ☐ "Shaken baby syndrome"
- ☐ Signs of illness
- ☐ Emergency/911
- ☐ Passive smoke
- ☐ Parenting practices
- ☐ "Safe at home"
- ☐ Potential for abuse
- ☐ Childcare safety
- ☐ Limit TV/Video exposure
- ☐ Postpartum adjustment
- ☐ Family involvement
- ☐ Parent/Infant attachment
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Birth-to-Three** ☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age

4 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA _____	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: _____ Formula (type): _____

Developmental Screen: Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) _____ Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? Hep B ____ **DTaP** ____ **IPV** ____ **Hib** ____ **PCV** ____ **Other** ____

ANTICIPATORY GUIDANCE

- ☐ **May introduce baby food slowly**
- ☐ Early dental decay
- ☐ Supine sleep position
- ☐ Injury prevention/"Baby-proofing"
- ☐ Safety with siblings and pets
- ☐ Drowning prevention/ Sun safety
- ☐ Car seat/Auto safety
- ☐ "Shaken baby syndrome"
- ☐ Signs of illness
- ☐ Emergency/911
- ☐ Passive smoke
- ☐ Parenting practices
- ☐ "Safe at home"
- ☐ Potential for abuse
- ☐ Child care safety
- ☐ Limit TV/Video exposure
- ☐ Postpartum adjustment
- ☐ Family involvement
- ☐ **Fears and phobias**
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Birth-to-Three** ☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age

6 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA _____	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Solids: _____

Developmental Screen: Age Appropriate? (e.g., rolls over, transfers small objects, vocal imitation) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) _____ Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

SCREENINGS:

Verbal Lead Risk Assessment

Yes/ No

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** Yes ___ No _____ **Delayed?** _____ **Deferred?** _____

Given today? Hep B _____ **DTaP** _____ **IPV** _____ **Hib** __ **PCV** _____ **Other** _____ **Influenza** _____

ANTICIPATORY GUIDANCE

- ☐ **Finger foods**
- ☐ **Introduce cup use**
- ☐ **Teething/Early dental decay**
- ☐ **Dental gum care**
- ☐ Supine sleep position
- ☐ Injury prevention/ "Baby - proofing"
- ☐ Safety with siblings and pets
- ☐ Drowning prevention/ Sun safety
- ☐ Car seat/Auto safety
- ☐ "Shaken baby syndrome"
- ☐ Emergency/911
- ☐ Passive smoke
- ☐ Parenting advice
- ☐ "Safe at home"
- ☐ Potential for abuse
- ☐ Child care safety
- ☐ Limit TV/Video exposure
- ☐ Family involvement
- ☐ **Interaction with parents**
- ☐ **Parental/Sibling adjustment**
- ☐ Fears and phobias
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Birth-to-Three** ☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age

9 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code –*circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA _____	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:
Pulse:
Resp:
Fluoride checked? (if well water)

Dental Screen: Brushing teeth? Yes No Education re: Limit sugar intake/give healthy snacks? Yes No

Nutritional Screen: Breast Feeding: Formula (type): Solids:

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

Tuberculin Test **(perform if at risk)**

Blood lead test/ referral (or perform at 1 year)

Additional Labs Ordered:
Hgb/Hct (HRisk/WIC) _____
Urinalysis _____
Other:

Behavioral /Developmental Screen
☐ Home Environment
☐ General Screen (e.g. PEDS or other tool)
☐ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _____ **No** _____ **Delayed?** _____

Given today? **Hep B** _____ **Hib** _____ **DTap** _____ **PCV** _____ **Influenza** _____ **IPV** _____ **Other** _____

ANTICIPATORY GUIDANCE PROVIDED

- ☐ Finger foods/Self-feeding
- ☐ **Transition to cup**
- ☐ Early dental decay
- ☐ **Sleep practices**
- ☐ Injury prevention/ "Babyproofing"/ Poison Control #
- ☐ Safety with Siblings and Pets
- ☐ **Drowning Prevention/sun safety**
- ☐ **Car seat/auto safety**
- ☐ "Shaken baby syndrome"
- ☐ Emergency/911
- ☐ Passive Smoke
- ☐ **Parenting Advice**
- ☐ "Safe at Home"
- ☐ Potential for abuse
- ☐ Child Care Safety
- ☐ Limit TV/Video Exposure
- ☐ **Time with parents/reading**
- ☐ Family Involvement
- ☐ Interactions with Parents
- ☐ **Stranger Awareness**
- ☐ **Sibling Interactions**
- ☐ **Parental Adjustment**
- ☐ **Family functioning**
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Birth to Three** ☐ **Dental** ☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age.

12 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code –*circle one* 99382-New, 99392-Estab
Accompanied by:		Allergies: ☐ NKA _____			Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp: _____
Pulse: _____
Resp:

Fluoride checked? (if well water)

Dental Screen: Daily tooth brushing? Yes No Frequency of sugar intake, & snacks low in sugar, discussed? Yes No

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____ Solids: _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

Tuberculin Test **(perform if at risk)**

Verbal Lead Risk Assessment

Blood lead test/referral (if not done at 9 mos.)

Additional Labs Ordered:

Hgb/Hct (HRisk/WIC) _____

Urinalysis _____

Other:

Behavioral /Developmental Screen

☐ Home Environment
☐ **General Screen** (e.g. PEDS or other tool)
☐ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS **Pt. needs immunizations?** **Yes** _____ **No** ____ **Delayed?** ____ **Deferred?** _____

Given today? **Hep** ____ **Hib** ____ **IPV** _____ **PCV** _____ **Influenza** ____ **DTap** ____ **MMR** _____

ANTICIPATORY GUIDANCE PROVIDED

- ☐ **Nutrition/Self-feeding**
- ☐ Transition to cup
- ☐ **Dental caries prevention**
- ☐ Sleep practices
- ☐ "Babyproofing"/Poison Control #
- ☐ Safety with Siblings and Pets
- ☐ Drowning Prevention /sun safety
- ☐ Car seat/auto safety
- ☐ Emergency/911
- ☐ Passive Smoke
- ☐ "Safe at Home?"
- ☐ Parenting Advice
- ☐ Potential for abuse
- ☐ Child Care Safety
- ☐ Limit TV/Video Exposure
- ☐ Time with parents/reading
- ☐ Stranger Awareness
- ☐ **Social interactions/ expectations**
- ☐ Sibling interactions
- ☐ Family functioning
- ☐ Parental Adjustment
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Behavioral** ☐ **Birth to Three** ☐ **Dental** ☐ **Nutritional**

☐ **Specialty** ☐ **Other**

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age.

15 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code –*circle one* 99382-New, 99392-Estab
Accompanied by:		Allergies: ☐NKA _____			Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Dental Screen: Daily toothbrushing? Yes No Education re: Frequency of sugar intake/ Healthy Snacks? Yes No

Nutritional Screen: Breast/whole milk: Table foods: Supplements: Cup:

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

Tuberculin Test _____
(perform if at risk)

Verbal Lead Risk Assessment

Blood lead test (if not previously done)

Additional Labs Ordered:

Hgb/Hct (HRisk/WIC)

Urinalysis

Other:

Behavioral /Developmental Screen

☐ Home Environment

☐ **General Screen** (e.g. PEDS or other tool)

☐ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred ?** ____ **Influenza** ____

Given today? **Hep B** ____ **DTaP** ____ **Hib** ____ **IPV** ____ **MMR** ____ **Varicella** ____ **PCV** ____

ANTICIPATORY GUIDANCE PROVIDED

- ☐ Nutrition/Exercise
- ☐ Dental caries prevention
- ☐ Sleep practices
- ☐ Injury prevention/"Child-proofing"
- ☐ Drowning Prevention /sun safety
- ☐ Car seat/auto safety
- ☐ **Fire Safety**
- ☐ Emergency/911
- ☐ Passive Smoke
- ☐ Parenting advice
- ☐ "Safe at Home?"
- ☐ Potential for abuse
- ☐ Child Care Safety
- ☐ Time with parents/reading
- ☐ Limit TV/Video Exposure
- ☐ Sibling interactions
- ☐ Family functioning
- ☐ Parental Adjustment
- ☐ Social Interactions/ Expectations
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Behavioral** ☐ **Birth to Three** ☐ **Dental** ☐ **Nutritional**

☐ **Specialty** ☐ **Other** ***Date Consult Report Received:***

Clinician Name (print) Clinician Signature See Additional/supervisory Note? Yes No

Update 1-06

Bold = First asked this age.

24 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code –*circle one* 99382-New, 99392-Estab
Accompanied by:		Allergies: ☐ NKA _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile: BMI: Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (If well water)

Dental Screen: Routine: Urgent: Parent advised: Brushing teeth? Yes No

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits *(ABR, OAE)*: Yes No **Speech:** Within normal limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

- Tuberculin Test (perform if at risk)
- Verbal Lead Risk Assessment
- Blood lead test referral

Additional Labs Ordered:

- Hgb/Hct (HRisk/WIC) _____
- Urinalysis _____
- Other:

Behavioral /Developmental Screen

- ☐ Home Environment
- ☐ General Screen (e.g. PEDS or other tool)
- ☐ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: Pt. needs immunizations? Yes ____ No ____ Delayed? ____ Deferred? ____

Given today? ____ Hep B ____ Varicella ____ Influenza ____ HIB ____ Other ____

ANTICIPATORY GUIDANCE PROVIDED

- ☐ Nutrition/exercise/vitamins
- ☐ Dental caries prevention/ dental care
- ☐ Discontinue Pacifier Use
- ☐ Injury prevention/ "Childproofing"
- ☐ Poisonous Plant Awareness
- ☐ Safety with Siblings and Pets
- ☐ Drowning Prevention /sun safety
- ☐ Car seat/auto safety
- ☐ Violence Prevention/gun safety
- ☐ Fire Safety/Burns
- ☐ Emergency/911
- ☐ Passive Smoke
- ☐ Parenting advice
- ☐ "Safe at Home?"
- ☐ Potential for abuse
- ☐ Child Care Safety
- ☐ Toilet training
- ☐ Read to child
- ☐ Limit TV/Video exposure
- ☐ Family involvement
- ☐ Fears and Phobias
- ☐ Peer Companionship
- ☐ Self control
- ☐ Sexual self-awareness
- ☐ Next appointment

REFERRALS: ☐ WIC ☐ Behavioral ☐ Birth to Three ☐ Dental ☐ Nutritional ☐ Speech ☐ Specialty ☐ Other

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

3 Year Old — Well Care EPSDT Tracking Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. Code – circle one 99382-New, 99392-Estab
Accompanied by:		Allergies: ☐ NKA _____		Current Medication(s)	

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam (if able)
OD _____
OS _____
OU _____
Corrected / uncorrected

Temp:
Pulse:
Resp:
BP :
Fluoride checked? (If well water)

Dental Screen: Next appt: Routine Urgent
Date of Last exam/referral:

Parent advised
Brushing child's teeth?

Nutritional Screen: Adequate Inadequate Supplements:

Physical Activity:

Hearing Screen: Within normal limits? (Audiometry) Yes No **Speech:** Within Normal Limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

Tuberculin Test
(perform if at risk)

Verbal Lead Risk Assessment

Blood lead test **(If not done at age 24 months)** _____

Additional Labs Ordered:
Hgb/Hct (HRisk/WIC) _____
Urinalysis _____
Other:

Behavioral /Developmental Screen
☐ Home Environment
☐ **General Screen** (e.g. PEDS or other tool)
☐ Activities (risk level)
☐ School Readiness

ASSESSMENT & PLAN: (Confidential Documentation attached)

IMMUNIZATIONS **Given Today?** _____ **Hep B** _____ **Varicella** _____ **PCV** _____
Hep A _____ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE PROVIDED

- ☐ Nutrition/ exercise/ vitamins
- ☐ Dental care
- ☐ Injury Prevention/"Childproofing
- ☐ Poisonous Plant Awareness
- ☐ Safety with Siblings and Pets
- ☐ Drowning Prevention/Sun Safety
- ☐ Car Seat /Auto safely
- ☐ **Sport bike/helmet use**
- ☐ Violence Prev./Gun Safety
- ☐ **Pedestrian/Traffic Safety**
- ☐ Emergency/911
- ☐ Passive Smoke
- ☐ Parenting advice
- ☐ "Safe at home?"
- ☐ Potential for abuse
- ☐ Child Care Safety
- ☐ Reading/ Preschool
- ☐ Toilet training
- ☐ Limit TV/Video/ Exposure
- ☐ **Discourage Thumbsucking**
- ☐ Family involvement
- ☐ Limits/Consequences
- ☐ Social Interactions/ Expectations
- ☐ Sexual Self-awareness
- ☐ Peer Companionship
- ☐ **Next appointment**

REFERRALS: ☐ **WIC** ☐ **Behavioral/ Developmental** ☐ **Dental** ☐ **Nutritional**
☐ **Speech** ☐ **Other** _____

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age.

BREAST MILK PROCEDURE

State Form 49954 (R5 / 3-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Breast milk is a very special product. Provide a safe and excellent source of nutrition to your breast-fed infants by following the procedure below:

1. The facility or the mother must supply sterilized bottles or disposable nurser bags (*see "Parent Agreement"*).

2. The mother will store her milk in a bottle or bag and refrigerate or freeze the milk. The bottle or bag should contain no more than the amount of milk the child would drink at one feeding. The milk must be labeled with the child's name and the date and time collected.

3. The bottles or disposable bags must be brought to the center in a clean, insulated container which keeps the milk at 41° F or below (*see "Parent Agreement"*).

4. Fresh, refrigerated breast milk must be used within forty-eight (48) hours of the time expressed. Frozen milk may be stored in a refrigerator freezer for three (3) to six (6) months or stored in a deep freezer at -4° F for six (6) to twelve (12) months.

5. Frozen breast milk may be thawed as follows:

   (a) Frozen breast milk may be thawed under warm water, gently swirled, used within one (1) hour or refrigerated immediately and used within twenty-four (24) hours. Label the bottle with the time and date thawed and method used for thawing (*"warm water" or "heat thaw"*).

   (b) Frozen breast milk may be thawed in the refrigerator at 41° F or below. Label the bottle with the time and date moved to the refrigerator and "cold thaw" method and use within twenty-four (24) hours. With this method, **never warm** the breast milk until ready to feed the child.

   (c) Do not refreeze the breast milk once it has been thawed.

NEVER HEAT BREAST MILK IN A MICROWAVE!

Note: Once a bottle is fed to infant, the remainder **must be discarded** and cannot be returned to the refrigerator.

PARENT AGREEMENT

I, _____, agree to provide my breast milk for my child _____ in sterilized bottles or sterile nurser bags. I will store my milk in the appropriate serving size for my child. I take full responsibility for maintaining this milk at 41° F or below during home storage and transport to the center.

Signature of parent	Date (*month, day, year*)

SUPPLEMENTAL HEALTH CARE PROGRAM FOR CHILD CARE CENTERS PROVIDING INFANT-TODDLER CARE SUGGESTED FEEDING PLAN

State Form 49963 (R3 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

INSTRUCTIONS:
Prior to admission, a feeding plan shall be established and written for each infant (age six (6) weeks to twelve (12) months) in consultation with the parents and based on the written recommendation of the child's medical provider. Feeding plans must be continually updated by the child's medical provider or parent. [470 IAC 3-4.7 (b)]

The following feeding plan has been recommended for this child.

Name of child	Date of birth (*month, day, year*)

Age in Months	Time to Feed	Formula / Food Item and Amount	Special Instructions	Signature and Date of Parent or Medical Provider

Signature of MD, DO, NP	Date signed (*month, day, year*)

FEEDING PLAN GUIDELINES

INSTRUCTIONS: This is a guideline. Each child will grow at a different rate.

1. *Formula and juice may be offered in a training cup when a child is ready.*
2. *Formula is used until twelve (12) months unless otherwise stated by a physician.*
3. *Only plain, strained, mashed or chopped vegetables, fruits and meats are offered.*
4. *Most children are ready for foods of coarser consistency between nine (9) to ten (10) months of age. Mashed or chopped table foods may be used.*
5. *Strained or mashed foods may be introduced at six (6) months if the infant's neuromuscular system has developed appropriately. Indications for solid foods are: the ability to swallow non-liquid foods, to sit with support, head and neck control, and to show that the child is able to decline food by leaning back or turning away.*
6. *Finger foods may be offered between nine (9) to twelve (12) months when infant is developing finger / hand coordination.*
7. *The serving of juice to children under twelve (12) months of age is discouraged.*

2 MONTHS - 5 MONTHS				
TIME INTERVAL	**AMOUNT EACH FEEDING**			
	Month 2	Month 3	Month 4	Month 5
6:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
10:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
2:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
6:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
10:00 p.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.
2:00 a.m.	4 - 6 oz.	4 - 7 oz.	5 - 7 oz.	5 - 8 oz.

6 MONTHS - 12 MONTHS					
	Month 6	Month 7	Month 8	Month 9	Months 10, 11, and 12
Total Amount of Formula Per 24 Hours	30 - 48 oz.	30 - 32 oz.	29 - 31 oz.	26 - 31 oz.	24 - 32 oz.
7:00 a.m.	5 - 8 oz. formula 2 - 3T baby cereal *	6 oz. formula 2 - 3T baby cereal *	7 - 8 oz. formula 3 - 5T baby cereal *	7 - 8 oz. formula ** 4 - 6T baby cereal * 2 - 4T fruit	6 - 8 oz. formula ** (*1cup*) 1/4 - 1/2 baby cereal * 2 - 4T fruit
9:00 a.m.	5 - 8 oz. formula	6 oz. formula	1/2 cup Vitamin C fortified fruit or juice 1/4 dry toast or 1 cracker	1/2 cup Vitamin C fortified fruit or juice 1/2 dry toast or 2 crackers	1/2 cup Vitamin C fortified fruit or juice 1/2 dry toast or 2 crackers
12:00 Noon	5 - 8 oz. formula 1/2 dry toast or 2 crackers	6 oz. formula 2 - 3T strained vegetable	7 - 8 oz. formula 5 - 9T vegetable 2 - 4T fruit	7 - 8 oz. formula ** 1 - 2T meat 5 - 9T vegetable 2 - 4T fruit	6 - 8 oz. formula ** (*1 cup*) 2T meat 2 - 6T potato, rice, noodles 5 - 9T vegetable 4 - 6T fruit
3:00 p.m.	5 - 8 oz. formula	6 oz. formula 1/2 dry toast or 2 crackers	7 - 8 oz. formula 1/2 dry toast or 2 crackers	7 - 8 oz. formula ** 1/2 dry toast or 2 crackers	6 - 8 oz. formula ** (*1 cup*) 1/2 dry toast or 2 crackers
6:00 p.m.	5 - 8 oz. formula 2 - 3T baby cereal *	6 oz. formula 2 - 3T strained fruit 2 - 3T baby cereal *	7 - 8 oz. formula 5 - 9T vegetable 2 - 4T fruit 2 - 5T baby cereal *	7 - 8 oz. formula ** 5 - 9T vegetable 2 - 4T fruit 1T meat 4T baby cereal *	6 - 8 oz. formula ** (*1 cup*) 2T meat 2 - 6T potato, rice, noodles 2 - 4T vegetable 2 - 4T fruit
9:00 p.m.	5 - 8 oz. formula	May start sleeping through the night.			

* If dry cereal is used, mix cereal and formula in a bowl. Feed with a spoon.
** Formula may be offered in a training cup.