

Well Child Exam

Middle childhood 6-10 years



Date									
Patient name			DOB	Sex	Parent name				
Allergies				Current medications					
Prenatal/family history					Ethnicity				
Weight	Percentile	Height	Percentile	BMI	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

Interval history (include injury/illness, visits to other health care providers, changes in family or home) _____ _____
Nutrition <input type="checkbox"/> Grains _____ servings per day <input type="checkbox"/> Vegetables _____ servings per day <input type="checkbox"/> Fruits _____ servings per day <input type="checkbox"/> Whole Milk _____ servings per day <input type="checkbox"/> Meat/Beans _____ servings per day <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Fluoride prescribed
Elimination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Exercise assessment Physical activity _____ minutes per day
Sleep <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal findings and comments Additional area for comments on page 2
Screening Oral health <input type="checkbox"/> Oral health risk assessment (6 year olds) Hearing <input type="checkbox"/> Screening audiometry, (6 year olds; 7-10 year olds if risk assessment positive) <input type="checkbox"/> Parental observation/concerns Vision <input type="checkbox"/> Visual acuity ____R ____L ____Both <input type="checkbox"/> Parental observation/concerns Developmental surveillance <input type="checkbox"/> Social-emotional <input type="checkbox"/> Communicative <input type="checkbox"/> Cognitive <input type="checkbox"/> Physical development Procedures If Risk: <input type="checkbox"/> IPPD _____ (result) <input type="checkbox"/> Hct or Hgb _____ (result) <input type="checkbox"/> Cholesterol _____ (result) <input type="checkbox"/> Diabetes _____ (result) <input type="checkbox"/> Dyslipidemia _____ (result) at 6, 8, & 10 years <input type="checkbox"/> Lead level ____ mcg/dl (for 6 year olds - required for Medicaid)
Immunizations <input type="checkbox"/> Immunizations reviewed, given and charted – if not given, document rationale <input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Flu if high risk <input type="checkbox"/> Pneumonia if high risk <input type="checkbox"/> IPV <input type="checkbox"/> DTaP <input type="checkbox"/> MMR <input type="checkbox"/> Varicella or Chicken pox date _____ <input type="checkbox"/> Acetaminophen ____ mg. q. 4 hours

Patient unclothed Y N

Review of symptoms	Physical exam		Systems
	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<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"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Normal growth and development
 Tanner Stage _____
 Abnormal findings and comments
 If yes, see additional note area on next page
 Results of visit discussed with child/parent
 Y N

Plan
 History/problem list/meds updated
 Referrals
 Dental Transportation
 Children Special Health Care Needs
 Priority Health Case Mgmt 800 998-1037
 Other _____

Developmental questions and observations on page 2

Next Well Check: _____ years of age

Provider signature: _____

X _____

Anticipatory guidance/health education (✓ if discussed) Healthy and safe habits <input type="checkbox"/> Discuss avoiding alcohol, tobacco, drugs <input type="checkbox"/> Limit TV, video and computer games <input type="checkbox"/> Ensure physical activity and adequate sleep
Injury and illness prevention <input type="checkbox"/> Test smoke alarms <input type="checkbox"/> Booster seat/seat belt use in back seat <input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Teach outdoor, bike and water safety <input type="checkbox"/> Use bike helmet/protective sporting gear <input type="checkbox"/> Teach stranger and home safety <input type="checkbox"/> Gun safety <input type="checkbox"/> Consistent rules
Nutrition <input type="checkbox"/> Limit sugar and high-fat foods <input type="checkbox"/> Family meals <input type="checkbox"/> Teach nutritious and healthy food choices <input type="checkbox"/> Offer variety of healthy foods and include 5 servings of fruits & veggies every day
Oral health <input type="checkbox"/> Schedule dental appointment <input type="checkbox"/> Discuss flossing, fluoride, sealants
Sexuality education <input type="checkbox"/> Use age-appropriate books/literature <input type="checkbox"/> Encourage independence <input type="checkbox"/> Answer questions about puberty simply
Social competence <input type="checkbox"/> Reinforce limits and family rules <input type="checkbox"/> Praise child and encourage child to talk about feelings, school and friends <input type="checkbox"/> Read with child and listen to child read <input type="checkbox"/> Assign household tasks and responsibilities <input type="checkbox"/> Supervise child's activities <input type="checkbox"/> Encourage hobbies and interests <input type="checkbox"/> Spend individual time with child
Family support and relationships <input type="checkbox"/> Listen/respect/show interest in child's activities <input type="checkbox"/> Eat meals as a family <input type="checkbox"/> Spend family time together <input type="checkbox"/> Set reasonable but challenging goals <input type="checkbox"/> Encourage positive interaction with siblings, teachers and friends <input type="checkbox"/> Offer constructive ways to handle family conflict and anger; don't allow violence <input type="checkbox"/> Know child's friends and their families <input type="checkbox"/> Be a positive role model for your child <input type="checkbox"/> Substance abuse, child abuse, domestic violence prevention, depression
Community interaction <input type="checkbox"/> Ask for referrals/resources as needed <input type="checkbox"/> Volunteer and participate in school activities <input type="checkbox"/> Ensure safe and supervised after-school care
Physical activity <input type="checkbox"/> Assess and counsel on ways to increase activity level <input type="checkbox"/> Physical activity & adequate sleep

Date	Patient name	DOB
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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 toddler is behaving or developing:

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- My child has hobbies or interests that he/she enjoys.
 - My child follows rules in home, school and the community, most of the time.
 - My child's behavior, relationships and school performances are appropriate most of the time.
 - My child handles stress, anger, frustration well, most of the time.
 - My child eats breakfast every day.
 - My child is doing well in school.
 - My child talks to me about school, friends and feelings.
 - My child seems rested when he/she wakes up.
 - My child gets some physical activity every day.

Ask the parent to respond to the following statements:

Yes No

- I know what to do when I am frustrated with my child.
- I enjoy seeing my child become more independent and self-reliant.
- Our family has experienced major stresses and/or changes since our last visit.
- It is harder for me every day to do what my child needs because of the sadness that I feel.

Ask the child to respond to the following statements:

Yes No

- I feel good about my friends and school.
- I know what to do when another child or adult tries to bully me or hurt me.

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).

Child development			Parent development		
States phone number and home address	Yes	No	Reading and math are at grade level	Yes	No
Has close friend(s)	Yes	No	Child communicates/expresses self	Yes	No
Child responds to parent and health care provider	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:

Family history update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who _____ what age _____
- New medical diagnosis: who _____ what age _____
- Anything else in your family history you have concerns or questions with: (Refer to family history form)

Staff signature: _____ **Provider signature:** _____

Patient education:

Child: 6-10 years

Milestones: Ways your child is developing between 6 and 10 years of age

- Your child should continue to lose baby teeth and get permanent teeth.
- Some girls' breasts will begin to grow between 8 and 10 years of age. Talk with her about her growing body as this starts to happen.
- Eight year olds can make their own bed, set the table, and bathe themselves, and grow more independent.
- Help your child learn new skills by talking and playing with them. Make a game of practicing hand signals or saying "No" when a stranger offers them a ride.
- Your child will keep growing more independent.

Safety tips

- Make sure everyone who rides in the car with you wears their seat belt. Help your child know how to ask to use a seat belt or booster when he/she rides with other drivers.
- Practice family safety in your house: test the smoke alarm and change the batteries when needed; have fire drills and practice crawling under the smoke and ways to get out of the house or building.
- Your child should always wear a life jacket around water, even after he/she has learned to swim.
- Make sure your child wears a helmet when using bikes, skates, inline skates, scooters, and skateboards. Practice safe walking and bike riding. Children are not ready to ride on streets or cross streets without an adult until age 9.
- Teach your child to never touch a gun. If they find one, they should tell an adult right away. Make sure any guns in your home are unloaded and locked up.

Health tips

- Your child will still need you to help get all of their teeth brushed well. Make sure to take your child for a dental check-up at least once a year. Ask about dental sealants.
- You and your child should exercise 60 minutes each day. It doesn't have to be all at once. Find activities that you and your child enjoy. This is an important habit for your child to learn. Talk to your child's doctor about ways to increase activity levels.
- Keep healthy snacks available. Your child needs fruit, vegetables, juice, and whole grains for growth and energy. Talk to your child's doctor about ways to improve healthy eating.
- Be sure to schedule your child's well-child visit between 11-12 years of age. Michigan schools are required by law to assess and report the immunization status of all 6th grade students. Failure to do so requires the school to exclude the child from attendance unless the child is in a close waiting period.

Parenting tips

- Praise your child when he/she works hard and finishes things. Most children learn by watching and then doing. Show and tell him/her how to do a job. Then have them do it while you watch. Tell her what she did right first, and then what she needs to do differently. Repeat as needed.
- Talk about why children should not use drugs and alcohol. Set a good example for your child.
- Teach your child what to do and not do when angry.
- Eat together as often as possible. Turn off the TV, unplug the phone, and enjoy each other.
- Set limits and tell your child what will happen if he/she doesn't follow rules.
- Teach your child how to deal with peer pressure.
- Encourage your child to join community groups, team sports, and other activities.

When you are a parent you will be happy, mad, sad, frustrated, angry, and afraid, at times. This is normal.

If you feel very mad or frustrated:

- Make sure your child is in a safe place and walk away.
- Call a friend to talk about what you are feeling.
- Call the free Parent Helpline at 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day.

For help or more information

Priority Health

Customer Service 616 942-1221 or 800 446-5674

Medicaid 888 975-8102

Behavioral Health 616 464-8500 or 800 673-8043

priorityhealth.com

Mental health

Association for Children's Mental Health (ACMH)

888 226-4543, *acmh-mi.org*

Domestic Violence

National Domestic Violence Hotline

800 799-SAFE (7233), *ndvh.org*

Child abuse and neglect information hotline

800 942-4357

Michigan Coalition Against Domestic & Sexual Violence 517 347-7000

or online at *mcadsv.org*

Childhelp National Child Abuse Hotline 800 4-A-CHILD (422-4453) or

online at *childhelp.org*

Parenting skills or support

Parents Hotline 800 942-4357

Family Support Network of Michigan 800 359-3722

Prevention of unintentional childhood injuries:

National Safe Kids Campaign 202 662-0600 or *usa.safekids.org*

Fire safety

Talk with firefighters at your local fire station

Poison prevention

Call the Poison Control Center

800 222-1222 or online at *mitoxic.org/pcc*