Patient Name:_____

Tuberculosis (TB) Risk Assessment

Circle Yes or No

			*If Yes, please explain
1. Is the child in close contact to a person with active TB disease?*	Yes	No	_____
2. Does the child have or is at risk to have HIV?	Yes	No	_____
3. Was the child or the child's parent born outside the US?	Yes	No	_____
4. Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No	_____
5. Is the child exposed to a person who has HIV, who is homeless or who lives in nursing home or another group home?	Yes	No	_____
6. Is the child exposed to drug users or migrant farm workers?	Yes	No	_____
7. Does the child have a health problem that lowers the immune system?	Yes	No	_____
8. Does the child live in a community that has a high risk for TB?	Yes	No	_____
9. Has the child traveled to or had any visitors from any foreign country since the last visit?	Yes	No	_____
10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray?*	Yes	No	_____

*** Call the Health Department**

Vision Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Has anyone in your child's family been diagnosed with congenital cateracts, retinoblastoma, metabolic disease, or ocular abnormalities?	Yes	No	_____
2. Has anyone in your child's family been diagnosed with amblyopia (blurred vision) or strabismus (lazy eye)?	Yes	No	_____
3. Has anyone in your child's family been diagnosed with epiphoria (excessive watery eyes), photophobia (light sensitivity), ptosis (drooping of the upper eyelid), or anisocoria (unequal pupil size)?	Yes	No	_____
4. Has anyone in your child's family had glaucoma, eye surgery, or glasses	Yes	No	_____
5. Do your child's eyes appear unusual?	Yes	No	_____
6. Does your child seem not to see well?	Yes	No	_____
7. Does your child exhibit difficulty with near or distance vision?	Yes	No	_____
8. Do your child's eyes appear not to be straight?	Yes	No	_____
9. Do your child's eyelids droop or does one eyelid tend to close?	Yes	No	_____
10. Has your child ever had an eye injury?	Yes	No	_____

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

Patient Name: _____

Lead Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Does your child live in or often visit a house that may have been built before 1978?	Yes	No	_____
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?	Yes	No	_____
3. Does your child live with or often visit another child that has an elevated blood lead level?	Yes	No	_____
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?	Yes	No	_____
5. Does your child chew on or eat any non-food items like paint chips or dirt?	Yes	No	_____
6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?	Yes	No	_____
7. Does your child receive medicines such as *greta, azarcon,kohl or pay-loo-ah*?	Yes	No	_____

Risk Factors for Hearing Loss

1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay	Yes	No
2. Family history of permanent childhood hearing loss	Yes	No
3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion	Yes	No
4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis	Yes	No
5. Craniofacial anomalies, especially involving the ear and temporal bone	Yes	No
6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction	Yes	No
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss	Yes	No
8. Neurodegenerative disorders or sensory motor neuropathies	Yes	No
9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis	Yes	No
10. Head trauma	Yes	No
11. Chemotherapy	Yes	No
12. Recurrent or persistent ear infection for at least 3 months	Yes	No

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

Patient Name: _____

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

◆ 18 Month ◆ Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

name

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, score "yes" for the item.

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. When your child wants something, does she tell you by *pointing* to it?	❑	❑	❑	____
2. When you ask him to, does your child go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat" or "Go get your blanket.")	❑	❑	❑	____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	❑	❑	❑	____
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Check "yes" even if her words are difficult to understand.)	❑	❑	❑	____
5. Without showing him first, does your child *point* to the correct picture when you say, "Show me the kitty" or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	❑	❑	❑	____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "Bye-bye," "All gone," "All right," and "What's that?")	❑	❑	❑	____

Please give an example of your child's word combinations:

_____

COMMUNICATION TOTAL ____

	YES	SOMETIMES	NOT YET	
GROSS MOTOR *Be sure to try each activity with your child.*				
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	❑	❑	❑	____
2. Does your child move around by walking, rather than by crawling on her hands and knees?	❑	❑	❑	____
3. Does your child walk well and seldom fall?	❑	❑	❑	____
4. Does your child climb on an object such as a chair to reach something he wants?	❑	❑	❑	____
5. Does your child walk down stairs if you hold onto one of her hands? (You can look for this at a store, on a playground, or at home.)	❑	❑	❑	____
6. When you show him how to kick a large ball, does your child try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) 	❑	❑	❑	____

GROSS MOTOR TOTAL ____

Name

	YES	SOMETIMES	NOT YET	

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)

❑ ❑ ❑ ___

2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.) ❑ ❑ ❑ ___

3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw?

❑ ❑ ❑ ___

4. Does your child stack three small blocks or toys on top of each other by herself? (You can also use spools of thread, small boxes, or toys that are about 1 inch in size.) ❑ ❑ ❑ ___

5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) ❑ ❑ ❑ ___

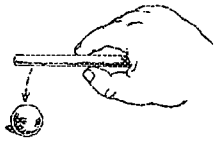
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? ❑ ❑ ❑ ___

FINE MOTOR TOTAL ___

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. Does your child drop several (six or more) small toys into a container, such as a bowl or box? (You may show him how to do it.) ❑ ❑ ❑ ___

2. After you have shown her how, does your child try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



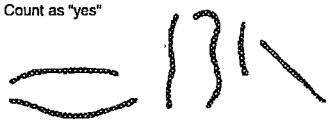
❑ ❑ ❑ ___

3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child purposely turn the bottle over to dump it out? You may show him how to do this. You can use a plastic soda-pop bottle or baby bottle. ❑ ❑ ❑ ___

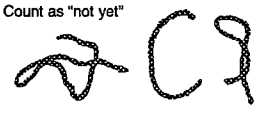
4. Without first showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? ❑ ❑ ❑ ___

5. After he watches you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction?* (Scribbling back and forth does not count as "yes.")

Count as "yes"



Count as "not yet"



❑ ❑ ❑ ___

Name

	YES	SOMETIMES	NOT YET	
PROBLEM SOLVING *(continued)*				
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show her how.) (Please allow a few minutes between trying problem solving items 3 and 6.)	❑	❑	❑	____ *
PROBLEM SOLVING TOTAL				.....

**If problem solving item 6 is marked "yes" or "sometimes," mark problem solving item 3 as "yes."*

PERSONAL-SOCIAL *Be sure to try each activity with your child.*				
1. While looking at himself in the mirror, does your child offer a toy to his own image?	❑	❑	❑	____
2. Does your child play with a doll or stuffed animal by hugging it?	❑	❑	❑	____
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	❑	❑	❑	____
4. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?	❑	❑	❑	____
5. Does your child drink from a cup or glass, putting it down again with little spilling?	❑	❑	❑	____
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	❑	❑	❑	____
PERSONAL-SOCIAL TOTAL				____

OVERALL *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

1. Do you think your child hears well?	YES ❑	NO ❑
If no, explain:		
2. Do you think your child talks like other toddlers his age?	YES ❑	NO ❑
If no, explain: _____		
3. Can you understand most of what your child says?	YES ❑	NO ❑
If no, explain: _____		
4. Do you think your child walks, runs, and climbs like other toddlers her age?	YES ❑	NO ❑
If no, explain: _____		
5. Does either parent have a family history of childhood deafness or hearing impairment?	YES ❑	NO ❑
If yes, explain:		

Name

OVERALL *(continued)*

6. Do you have concerns about your child's vision? YES ❑ NO ❑

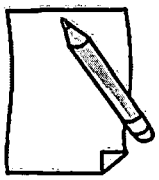
   If yes, explain: _____

7. Has your child had any medical problems in the last several months? YES ❑ NO ❑

   If yes, explain: _____

8. Does anything about your child worry you? YES ❑ NO ❑

   If yes, explain: _____



Developmental Drawing Sheet

Please use this sheet to allow your child to show us their creativity. This is not only fun for your child, but also allows us to observe fine motor and cognitive skills. Several age groups are listed. Find your child's age and ask them to complete the activities for that age. Remember to allow your child to practice these skills with you at home. Coloring is fun and great for your child's brain development. When you are done, draw a picture on the back of the page.

15 Months- 30 Months Old: Let your child use your pen and clipboard to have fun and scribble in the space below.

3 & 4 Years Old: Ask your child to copy the circle and cross pictured below & draw a person.

5 Years Old: Ask your child to draw a circle and cross, copy the square and triangle pictured below, print some letters and numbers, & draw a person.

CIRCLE:

CROSS:

Draw us a picture below

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

VACCINE INFORMATION STATEMENT

Hepatitis A Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis A is a serious liver disease. It is caused by the hepatitis A virus (HAV). HAV is spread from person to person through contact with the feces (stool) of people who are infected, which can easily happen if someone does not wash his or her hands properly. You can also get hepatitis A from food, water, or objects contaminated with HAV.

Symptoms of hepatitis A can include:

- fever, fatigue, loss of appetite, nausea, vomiting, and/or joint pain
- severe stomach pains and diarrhea (mainly in children), or
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements).

These symptoms usually appear 2 to 6 weeks after exposure and usually last less than 2 months, although some people can be ill for as long as 6 months. If you have hepatitis A you may be too ill to work.

Children often do not have symptoms, but most adults do. You can spread HAV without having symptoms.

Hepatitis A can cause liver failure and death, although this is rare and occurs more commonly in persons 50 years of age or older and persons with other liver diseases, such as hepatitis B or C.

Hepatitis A vaccine can prevent hepatitis A. Hepatitis A vaccines were recommended in the United States beginning in 1996. Since then, the number of cases reported each year in the U.S. has dropped from around 31,000 cases to fewer than 1,500 cases.

2 Hepatitis A vaccine

Hepatitis A vaccine is an inactivated (killed) vaccine. You will need **2 doses** for long-lasting protection. These doses should be given at least 6 months apart.

Children are routinely vaccinated between their first and second birthdays (12 through 23 months of age). Older children and adolescents can get the vaccine after 23 months. Adults who have not been vaccinated previously and want to be protected against hepatitis A can also get the vaccine.

You should get hepatitis A vaccine if you:

- are traveling to countries where hepatitis A is common,
- are a man who has sex with other men,
- use illegal drugs,
- have a chronic liver disease such as hepatitis B or hepatitis C,
- are being treated with clotting-factor concentrates,
- work with hepatitis A-infected animals or in a hepatitis A research laboratory, or
- expect to have close personal contact with an international adoptee from a country where hepatitis A is common

Ask your healthcare provider if you want more information about any of these groups.

There are no known risks to getting hepatitis A vaccine at the same time as other vaccines.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of hepatitis A vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If you are not feeling well.** If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis A vaccine do not have any problems with it.

Minor problems following hepatitis A vaccine include:
- soreness or redness where the shot was given
- low-grade fever
- headache
- tiredness

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**