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## **Anticipatory Guidance for the 24 Month Well Child Physician Visit**

Date \_\_\_\_\_

My child is \_\_\_\_\_ months old.

He/she weights \_\_\_\_\_ 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 or 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.



**COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START**

998 Washington St. N.  
PO Box 1238  
Twin Falls, Idaho 83303-1238  
208-736-0741



**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

Office Use Only:	Enrollment Date:	FE Name:
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Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Parent/Guardian Names: \_\_\_\_\_

How many meals and snacks are offered to your child daily: \_\_\_\_\_ Meals \_\_\_\_\_ Snacks

<b>Does your child:</b>	<b>How often?</b>	<b>Comments</b>
Drink from a bottle <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Drink from a cup <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take a bottle to bed <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____

**Does your child drink any of the following?**

Breast milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Formula	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	type _____
Cows milk (pasteurized)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	1%,2%,whole _____
Evaporated milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Soy or Rice Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Goats milk	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Water	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Tea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Kool-Aid/Soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Cows milk (raw)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____

<b>Does your child:</b>	<b>How Often?</b>	<b>Comments</b>
Take vitamin or mineral supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Take iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/day	_____
Eat non-food items? <input type="checkbox"/> Yes <input type="checkbox"/> 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:* \_\_\_\_\_

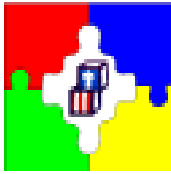
[If yes, Please fill out a Medical Food Substitution form](#)

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?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do your food dollars meet your family need?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child live in a home that has running water?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child live in a home that has a working stove and refrigerator? | <input type="checkbox"/> Yes <input type="checkbox"/> 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

<b>Time</b>	<b>Food/Drink Consumed</b>	<b>Amount Consumed (Cups, ounces, spoon-fuls, etc.)</b>	<b>Notes</b>

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