

DEVELOPMENTAL TASKS										
NORMAL	ABNORMAL					NORMAL	ABNORMAL			
<input type="checkbox"/>	<input type="checkbox"/>	Recognizes parents				<input type="checkbox"/>	<input type="checkbox"/>	Responds to loud sounds		
<input type="checkbox"/>	<input type="checkbox"/>	Lift head temporarily erect when held upright				<input type="checkbox"/>	<input type="checkbox"/>	Coos		
<input type="checkbox"/>	<input type="checkbox"/>	Regards face in direct line of vision				<input type="checkbox"/>	<input type="checkbox"/>	Social smile		
<input type="checkbox"/>	<input type="checkbox"/>	Grasps rattle when placed in hand				<input type="checkbox"/>	<input type="checkbox"/>			
Describe abnormal findings:										
DIET/ NUTRITION			IMMUNIZATIONS				LABORATORIES			
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DtaP #1				
Formula _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IPV #1				
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hib #1				
Fluoride supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hep B #1				
Vit. D in breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunization for age completed	yes	no		
Iron supp. in pre-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
<i>SUBJECTIVE</i>										
<i>OBJECTIVE</i>										
HEIGHT	WEIGHT		HEAD CIRCUMFERENCE			HR	RR			
	NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL	Describe Physical findings			
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Fontanelles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Red Reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<i>ASSESSMENT</i>										
<i>PLAN</i>										
					ANTICIPATORY GUIDANCE					
Provider's Signature					Next Appointment					
					Burns-Hot liquids					
					Do not lay in bed unattended					
					Sleep patterns					
					Observe parent-child interactions					
Provider's Stamp					Discuss solid food nutrition					
					BBTD					
Date					Immunizations					
					DTaP#2, Hep B #2, Hib #2, IPV #2					
 DETAINEE LABEL										