Preventive Care Forms

Age-Specific Encounter Forms *Updated 2014*

@mbw K_qq Glbcv &@KG' A_jasj_rmp + Afgjb $ Rccl

Snb_rcb 0./4

WHO & CDC Growth Charts *Updated 2014*

Medical and Family History Form - English & Spanish *Updated 2006*

Objective Hearing &Vision Form *Updated 2015*

PEDIATRIC VISIT 3 to 5 DAY

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____

Perinatal history documented ?_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Maternal Depression? Yes / No

Support?

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

Risk Assessment: **TB** Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin/Umbilicus _____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

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NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?

Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐

If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐

Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐

Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐

Sneezing, hiccoughs, soft spot ☐

Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐

Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120º ☐

Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐

Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐

Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Follow-up newborn hearing screen ☐ _____
3. Next preventive appointment ☐ _____
4. Referrals for identified problems? *(specify)*_____

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Signatures: _____

PEDIATRIC VISIT 0 to 1 MONTH

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____

Perinatal history documented & updated?_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Maternal Depression? Yes / No

Support?

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

Risk Assessment: **TB** Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin/Umbilicus _____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?

Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐

If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐

Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐

Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐

Sneezing, hiccoughs, soft spot ☐

Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐

Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120º ☐

Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐

Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐

Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen ☐ _____
3. Follow-up newborn hearing screen ☐ _____
4. Next preventive appointment ☐ _____
5. Referrals for identified problems? *(specify)*_____

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Signatures: _____

PEDIATRIC VISIT 2 to 3 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____

Perinatal history documented & updated?_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Maternal Depression? Yes / No

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, Loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

Risk Assessment: TB Circle: **Positive / Negative (Annual)**

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

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NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet _____, dry _____ in 24 hours?

Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐

If breast fed, Vitamin D ☐ Feed on demand ☐

Growth spurts ☐ Avoid solid foods until 4-6 months ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Regards face ☐ Alert ☐ Social smile ☐

Fine Motor: Follows 90 degrees ☐ Grasps ☐

Language: Coos ☐ Laughs ☐

Gross Motor: Head steady when sitting ☐ Hand brought to mouth ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐ Sibling rivalry ☐

Father's involvement ☐

Parenting: Comfort often ☐ Infant developing trust ☐

Holding much of time when awake ☐

Temperaments differ among infants ☐

Play and communication: Infant seat ☐ Mobiles, music, pictures ☐

Talk or sing to baby ☐ Objects to kick or bat at ☐

Health: Fever/taking temp ☐ Rashes ☐ Diarrhea ☐

Second hand smoke ☐

Injury prevention: Rear riding/rear facing infant car seat ☐

Smoke detector/escape plan ☐ Hot liquids ☐ Poison control # ☐

Hot water set at 120º ☐ Water safety (tub/pool) ☐

Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐

Fall prevention (heights) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen, if not done earlier ☐ _____
3. Follow up newborn hearing screen ☐ _____
4. Next preventive appointment at 4 months ☐
5. Referrals for identified problems? *(specify)*

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Signatures: _____

PEDIATRIC VISIT 4 to 5 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No
Risk Assessment: TB Circle: Positive / Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

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NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Can add cereal; use spoon ☐ Iron in formula ☐
If breast fed, Vitamin D and iron ☐
Introduce single ingredient foods one at a time ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Smiles ☐ Seeks eye contact with parent ☐

Fine Motor: Follows 180 degrees ☐ Grasps rattle ☐
Reaches for toy ☐ Hands together ☐

Language: Vocalizes ☐ Coos ☐ Laughs ☐

Gross Motor: Rolls over belly to back ☐ Lifts chest up ☐
Prone, lifts head 90 degrees ☐ Head steady when sitting ☐
Bears some weight on legs ☐

ANTICIPATORY GUIDANCE:

Social: Schedules/daily routines ☐ Sitter ☐

Parenting: Can't spoil ☐ Different babies have different temperaments ☐

Play and communication: Hanging toys ☐
Respond to baby's "conversation" ☐ Age appropriate toys ☐
Choose toys for shape, size and texture ☐

Health: Teething, drooling, chewing ☐ Clean teeth ☐
Second hand smoke ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Poison control # ☐
Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐
Fall prevention (heights) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations by schedule _____
2. Follow up newborn hearing screen _____
3. Next preventive appointment at 6 months ☐
4. Referrals for identified problems? *(specify)*

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Signatures: _____

PEDIATRIC VISIT 6 to 8 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, Loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB (Annual) LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
☐	☐	Skin
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Number of Teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Introduce single ingredient food weekly ☐
Offer cup ☐ Jar/table foods ☐ Avoid small hard foods ☐
Encourage self-feeding ☐ Only water in bedtime bottle ☐

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Shy with strangers ☐ Resists pull toy ☐ Plays peek-a-boo ☐

Fine Motor: Transfers toy hand to hand ☐ Feeds self crackers ☐ Works for toy out of reach ☐

Language: Dada or Mama (non-specific) ☐ Turns to voice ☐
Imitates speech sounds ☐

Gross Motor: Sits alone ☐ Stands holding on ☐
Bears weight on legs ☐ No head lag when pulled to sitting ☐

ANTICIPATORY GUIDANCE:

Social: Fear of strangers ☐ Separation anxiety ☐

Parenting: Emphasize protection over discipline ☐
Temper tantrums: ignore, distract ☐
May need reassurance for separation anxiety ☐

Play and communication: Water and sand play ☐
Toys with moving parts, holes, strings to pull ☐
Beginning speech sounds ☐

Health: Fluoride if well water ☐ Second hand smoke ☐
Clean teeth ☐ Use sunscreen ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Baby proof home ☐
Hot water set at 120º ☐ Poison control # ☐
Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Hot liquids ☐
Water safety (tub/pool) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test, if positive risk assessment ☐ _____
3. Follow up newborn hearing screen ☐ _____
4. Fluoride Varnish Applied? Yes / No
5. Next preventive appointment at 9 months ☐
6. Referrals for identified problems? *(specify)*

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Signatures:_____

PEDIATRIC VISIT 9 to 11 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB (Annual) LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dentition (# of teeth)
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

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NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____
Bowel/bladder: Number of wet____, dry____ in 24 hours?
Number BM's in 24 hours? _____

Education: Jar/table foods ☐ Offer cup ☐ Avoid small hard foods ☐ Encourage self-feeding/finger foods ☐ Expect messiness/playing with food ☐ Water only bedtime bottle ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Shy with strangers ☐ Plays patty cake ☐
Looks for fallen object ☐
Fine Motor: Bangs two cubes ☐ Pincer grasp ☐ Reaches, grabs ☐ Feeds self ☐ Drinks from cup ☐
Language: Dada or Mama (specific) ☐ Babbles ☐
Imitates speech sounds ☐
Gross Motor: Gets to sitting ☐ Pulls self to stand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Fear of strangers ☐ Separation anxiety ☐
Parenting: Emphasize protection over discipline ☐
Temper tantrums: ignore, distract ☐ May need reassurance for separation anxiety ☐
Play and communication: Water and sand play ☐ Toys with moving parts, holes, strings to pull ☐ Beginning speech sounds ☐
Health: Fluoride if well water ☐ Second hand smoke ☐
Clean teeth with soft toothbrush or cloth ☐ Use sunscreen ☐
Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Poison control# ☐
Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐
Fall prevention (heights) ☐ Baby proof home ☐
Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test referral (if positive risk assessment) ☐_____
3. Fluoride Varnish Applied? Yes / No_____
4. Next preventive appointment at 12 months ☐ _____
5. Referrals for identified problems? *(specify)*_____

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Signatures:_____

PEDIATRIC VISIT 12 to 14 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No_____
Evidence of neglect or abuse? Yes / No_____

RISK ASSESSMENT:

	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dental/Number of teeth _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

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_____
_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Phase out bottle ☐ Table foods ☐ Vitamins ☐
Decreased appetite ☐ Whole milk until age two ☐
Keep offering new foods ☐ Nutritious snacks ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Fear of strangers ☐ Separation anxiety ☐

Fine Motor: Scribbles ☐ Pincer grasp ☐ Drinks from cup ☐

Language: Dada or Mama (specific) ☐ 1 to 3 words ☐
Indicates wants ☐

Gross Motor: Stands alone ☐ "Cruises" ☐ Walks ☐ Stoops and recovers ☐ Plays ball with examiner ☐

ANTICIPATORY GUIDANCE:

Social: Fear of strangers ☐ Separation anxiety ☐

Parenting: Delay toilet training ☐ Negativism ☐ Autonomy ☐
Discipline means to teach ☐ Avoid spanking/slapping ☐

Play and communication: Varied activities ☐
Singing, naming, reading ☐

Health: Fever ☐ Fluoride if well water ☐ Brush teeth ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Poison control # ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test/HCT required ☐ _____
3. PPD, if positive risk assessment ☐ _____
4. Has parent renewed MA for infant? ☐
5. Dental visit advised ☐_____
6. Fluoride Varnish Applied? Yes / No_____
7. Next preventive appointment at 15 months ☐ _____
8. Referrals for identified problems? *(specify)*_____

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Signatures:_____

PEDIATRIC VISIT 15 to 17 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____

Family health history updated? _____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dental/Number of teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Only water in bedtime bottle ☐ Keep offering new foods ☐
Strong dislike for certain foods ☐ Phase out bottle, pacifier ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Imitates affection ☐ Helps with simple tasks ☐
Imitates housework ☐

Fine Motor: Scribbles spontaneously ☐ Uses cup ☐ Feeds self ☐
Tower of 2 cubes ☐

Language: 3 words other than Dada/Mama ☐ Immature babbling ☐
Points to 1-3 named body parts ☐ Understands simple commands ☐

Gross Motor: Crawls up steps ☐ Stoops and recovers ☐
Walks well ☐ Walks backward ☐ Removes garment ☐

ANTICIPATORY GUIDANCE:

Social: Child is egocentric ☐ Loves attention ☐
Seeks to control others ☐

Parenting: Child may bite, hit ☐ Use time out ☐
Temper tantrums: ignore, distract ☐ Avoid spanking/slapping ☐
Discipline is teaching ☐ Dependence verses autonomy needs ☐

Play and communication: Climbing, dancing, riding toys ☐
Likes to push/pull, empty/fill, open/close ☐ Read stories ☐
Enjoys household articles ☐

Health: Regression during illness/stress ☐ Proper shoes ☐
Teeth brushing ☐ Fluoride if well water ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Baby proof home ☐ Hot liquids ☐ Hot water set at 120º ☐
Water safety (tub/pool) ☐ Choking/suffocation ☐ Poison control # ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Review lead and HCT results ☐ _____
3. Refer for lead and HCT testing if not available ☐ _____
4. PPD, if positive risk assessment ☐
5. Dental visit advised ☐ or date of last dental exam_____
6. Fluoride Varnish Applied? Yes / No_____
7. Next preventive appointment at 18 months ☐ _____
8. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 18 to 23 MONTHS

DATE OF SERVICE_____

NAME_____ DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dentition (# of teeth) _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____
_____
_____

NUTRITIONAL ASSESSMENT:

Typical diet:

Education: Prolonged mealtime with playing ☐
Likes and dislikes change often ☐ Food jags okay ☐
Allow self-feeding ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

MCHAT Required ☐

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Removes clothes ☐ Helps with simple tasks ☐
Imitates housework ☐

Fine Motor: Scribbles ☐ Tower of 3-4 cubes ☐ Turns pages ☐

Language: Combines 2 words ☐ Points to 2-4 named body parts ☐
Follows directions ☐ Names picture (cat, bird, horse, dog, person) ☐
Uses 10-15 words ☐

Gross Motor: Kicks ball ☐ Throws ball ☐ Walks up steps ☐
Walks backward ☐

ANTICIPATORY GUIDANCE:

Social: Needs to be independent ☐ Stubbornness is normal ☐
Does not share well ☐

Parenting: Daily routines meet security needs ☐
Child constantly tests parent, self, siblings, environment ☐
"Time out" for hitting/biting ☐ Avoid spanking, slapping ☐
Forgets rules quickly, needs reminding ☐ Give choices ☐

Play and communication: Uses objects for imaginary play ☐
Manipulative toys (play dough, sand, paint) ☐ Read stories ☐
Thumb sucking and masturbation common ☐
Favorite toy, transitional object ☐

Health: May be toilet ready ☐ Brush teeth ☐ Fluoride if well water ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub, pool) ☐
Poison control no. ☐ Choking/suffocation ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS:

1. Immunizations ordered ☐ _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if risk assessment positive ☐ _____
4. Fluoride Varnish Applied? Yes / No
5. Dental visit advised ☐ or date of last dental visit _____
6. Next preventive appointment at 2 Years ☐_____
7. Referrals for identified problems: (specify)_____

Signatures:_____

PEDIATRIC VISIT 2 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____

Family health history updated?_____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

(Circle)	CHOL	TB	LEAD
	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐ Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

MCHAT Required ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐ Washes and dries hands ☐ Plays interactive games ☐ Separates from mother ☐

Fine Motor: Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐ Uses spoon well ☐

Language: Combines 2 words ☐ Knows 3-5 named body parts ☐ Follows 2 part directions ☐ Understands cold, tired, hungry ☐ Gives first and last name ☐ Picks longer line ☐ Names 1 picture (cat, bird, horse, dog, person) ☐

Gross Motor: Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐ Balances on 1foot-1 second ☐ Pedals tricycle ☐ Throws ball overhand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Aware of self/different from others ☐ Needs peer contact ☐ Dawdling is normal ☐ Resolving negativism ☐ Power struggles occur ☐

Parenting: Toilet training (relaxed, praise success) ☐ Sexuality ☐ Help teach self-control ☐ Offer choice, give simple tasks ☐ Tantrums (ignore, distract, sympathize) ☐

Play and communication: Small table and chairs ☐ Stories and music ☐ Building materials ☐

Health: Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐ Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐ Physical activity ☐ Second hand smoke ☐ Tick prevention ☐

Injury prevention: Car seat ☐ Rear riding seat ☐ Poison control # ☐ Hot water at 120º ☐ Water safety (tub, pool) ☐ Toddler proof home ☐ Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐

PLANS

1. Review immunizations and bring up to date ☐ _____
2. Second Lead/HCT test required ☐ _____
3. Speech referral if delayed ☐ _____
4. PPD, if risk assessment is positive ☐ _____
5. Dental visit advised ☐ Date of Last Dental Exam _____
6. Testing/counseling, if cholesterol risk assessment is positive_____
7. Fluoride Varnish Applied? Yes / No_____
8. Next preventive appointment at 30 Months ☐ _____
9. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 30 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____

Family health history updated?_____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

(Circle)	CHOL	TB	LEAD
	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐ Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED if not completed at 24 month visit

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

MCHAT Required ☐ if not completed at 24 month visit

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐ Washes and dries hands ☐ Plays interactive games ☐ Separates from mother ☐

Fine Motor: Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐ Uses spoon well ☐

Language: Combines 2 words ☐ Knows 3-5 named body parts ☐ Follows 2 part directions ☐ Understands cold, tired, hungry ☐ Gives first and last name ☐ Picks longer line ☐ Names 1 picture (cat, bird, horse, dog, person) ☐

Gross Motor: Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐ Balances on 1foot-1 second ☐ Pedals tricycle ☐ Throws ball overhand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Aware of self/different from others ☐ Needs peer contact ☐ Dawdling is normal ☐ Resolving negativism ☐ Power struggles occur ☐

Parenting: Toilet training (relaxed, praise success) ☐ Sexuality ☐ Help teach self-control ☐ Offer choice, give simple tasks ☐ Tantrums (ignore, distract, sympathize) ☐

Play and communication: Small table and chairs ☐ Stories and music ☐ Building materials ☐

Health: Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐ Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐ Physical activity ☐ Second hand smoke ☐ Tick prevention ☐

Injury prevention: Car seat ☐ Rear riding seat ☐ Poison control # ☐ Hot water at 120° ☐ Water safety (tub, pool) ☐ Toddler proof home ☐ Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐

PLANS

1. Review immunizations and bring up to date ☐ _____
2. Second Lead/HCT test required ☐ if not completed at 24 month visit_____
3. Speech referral if delayed ☐ _____
4. PPD, if risk assessment is positive ☐ _____
5. Dental visit advised ☐ Date of Last Dental Exam _____
6. Testing/counseling, if cholesterol risk assessment is positive_____
7. Fluoride Varnish Applied? Yes / No_____
8. Next preventive appointment at 3 Years ☐ _____
9. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 3 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____

Family health history updated? _____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____

Counseling provided? Yes / No_____

Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals _____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Offer variety of nutritious foods/snacks ☐ May be picky ☐
Eats same foods as family ☐ 5 fruits/vegetables daily ☐
No sweetened beverages ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Dresses self ☐ Separates easily ☐ Plays interactive games ☐

Fine Motor: Copies: O _____ + _____ ☐ _____

Language: Understands 2of 3: cold, tired, hungry ☐
Understands 3 of 4 prepositions (block is on, under, behind in front of table) ☐ Speech clear to examiner ☐ Recognizes 3-4 colors ☐
Uses plurals ☐ Gives first and last name ☐ Knows sex (boy/girl) ☐

Gross Motor: Balances on 1 foot for 1 second ☐ Jumps well ☐
Broad jump ☐ Pedals tricycle ☐

ANTICIPATORY GUIDANCE:

Social: Needs peer contact ☐ Caution with strangers/animals ☐ Sibling rivalry ☐ Develops pride with accomplishments ☐
Caution with strangers/animals ☐

Parenting: Time out for serious misbehavior ☐ Read parenting books ☐
Help child to release energy ☐ Avoid smacking, spanking ☐
Encourage talk about feelings (instead of misbehaving) ☐
Dependency needs alternate with independence ☐
Special times alone with child ☐ Praise child ☐

Play and communication: Excursions, outdoor play, art ☐ Library ☐
Read to child ☐ Make up stories together ☐ Screen TV shows ☐

Health: Dental care ☐ Fears ☐ Physical activity ☐
Begin sex education (boy/girl differences, "private parts", etc) ☐
Masturbation ☐ Fluoride if well water ☐ Tick prevention ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Rear riding car seat ☐ Bicycle helmets ☐ Matches ☐
Riding toys in traffic ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Hot water 120º ☐ Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Water safety (tub, pool) ☐
Toddler proof home ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at 4 Years ☐_____
7. Referrals for identified problems:*(specify)*_____

_____

Signatures:_____

PEDIATRIC VISIT 4 TO 5 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? Yes / No_____

Family health history updated? Yes / No_____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care**:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____

Counseling provided? Yes / No _____

Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Choose from food guide pyramid ☐ 2hrs or less TV/day ☐
Child can help prepare food for meals ☐ Mealtime can be fun ☐
5 fruits/vegetables daily ☐ Food jags ☐ 1 or more hrs. physical activity ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other**: ☐ *(specify)* _____

Results: Wnl ☐ **Areas of Concern**:_____

Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Toilets alone ☐ Dresses self ☐ Plays in group ☐
Separates from parent easily ☐

Fine Motor: Copies: O _____ + _____ ☐ _____
Uses scissors ☐ Draws person, 3 parts ☐

Language: Knows: What is:- spoon ☐; shoe ☐; door ☐;-made of?
Fluent sentences ☐ Recognizes 3-4 colors ☐ Defines 6-9 words: Ball ☐
Lake ☐ Desk ☐ House ☐ Banana ☐ Curtain ☐ Ceiling ☐ Fence ☐
Knows 2-3 opposites: fire is hot, ice is __ ☐; mom is woman, dad is __ ☐;
horse is big, mouse is ___ ☐

Gross Motor: Balances on 1 foot for 10 seconds (2-3 times) ☐
Hops ☐ Heel-toe walk ☐ Catches bounced ball ☐

ANTICIPATORY GUIDANCE:

Social: School readiness ☐ Enrolled in Pre-K/K ☐ School avoidance ☐
Management of aggression ☐ Promote self-help skills ☐
Caution with strangers/animals ☐

Parenting: Allow separation ☐ Promote initiative, creativity ☐
Awareness of ADHD and learning disabilities ☐

Play and communication: Monitor TV use ☐ Small chores ☐
Creative, active and group play ☐

Health: Dental care ☐ Fluoride if well water ☐ Bedwetting ☐ Fears ☐
Nightmares ☐ Leg aches ☐ Normal sexual curiosity; simple answers ☐
Masturbation ☐ Oedipal complex ☐ Use sunscreen ☐
Tick prevention ☐ Second hand smoke ☐

Injury prevention: Booster seat (up to 4'9") ☐ Ride in back seat ☐
Riding toys in traffic environment ☐ Bicycle helmets ☐ Matches ☐
Choking/suffocation ☐ Hot water 120º ☐ Water safety (tub, pool) ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Fall prevention (playground) ☐ Smoke detector/escape plan ☐
Firearms (look alike toys, owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐ _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*

_____

Signatures:_____

PEDIATRIC VISIT 6 to 11 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Child care:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB
(Circle)	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth _____
☐	☐	Skin _____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose/Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals/Tanner stage _____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose foods from food guide pyramid ☐ Sociable at table ☐
Lowfat food choices, including milk ☐ Choose healthy foods at school ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐ 2hrs or less TV ☐

DEVELOPMENTAL SURVEILLANCE:

School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Responsibility for self ☐, for school ☐ Competitiveness ☐
Family vs. peer activities ☐ Caution with strangers/animals ☐
Teach address and phone number ☐

Parenting: Increased autonomy in decisions ☐ Communicate ☐
Praise and encourage ☐ Give allowance ☐
Assist in handling money ☐ Establish fair rules ☐

Play and communication: Organized sports ☐ Hobbies ☐
Monitor TV use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐
Physical activity ☐ Smoking ☐ Second hand smoke ☐
Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Early sex education ☐
Masturbation ☐ Modesty ☐

Injury prevention: Seat belt ☐ Rear seat until age 12 years ☐
Riding toys in traffic environment ☐ Bicycle helmets ☐ Water safety ☐
Hot water 120º ☐ Fall prevention (playground) ☐ Matches ☐
Protective devices in sports ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, products) ☐ Poison control # ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Objective Hearing and Vision Tests (recommended)_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*_____

_____
_____
_____

Signatures:_____

PEDIATRIC VISIT 12 TO 13 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

RISK ASSESSMENT:

	CHOL	TB	STI/HIV
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:
Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods ☐ Sociable at table ☐
Avoid fad diets/eating disorders ☐ Select healthy snacks ☐
5 fruits/vegetables daily ☐ 2 hrs or less of TV/computer games ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:
Peer Relations:
Family Relations:
Extracurricular activities:
Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Family and peer activities ☐ Ownership and competition ☐
Responsibility for self and family ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Money, allowance ☐
Promote mutual & self-respect ☐ Respect privacy ☐ Allow decisions ☐
Spend time with child talking, projects ☐

Play and communication: Organized sports ☐
Monitor TV and internet use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Masturbation ☐
Modesty ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmet ☐ Riding in traffic ☐
Smoke detector/escape plan ☐ Poison control # ☐ Water safety ☐
Protective devices in sports ☐ Alcohol/drug use ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Recommend objective Hearing and Vision Tests ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Testing for sickle cell trait if original metabolic results not available ☐
7. Dental visit advised ☐ or date of last visit_____
8. Next preventive appointment at _____
9. Referrals for identified problems: Yes / No *(specify)*_____

_____
_____
_____
_____

Signatures:_____

PEDIATRIC VISIT 12 TO 13 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

RISK ASSESSMENT:

	CHOL	TB	STI/HIV
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:
Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods ☐ Sociable at table ☐
Avoid fad diets/eating disorders ☐ Select healthy snacks ☐
5 fruits/vegetables daily ☐ 2 hrs or less of TV/computer games ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:
Peer Relations:
Family Relations:
Extracurricular activities:
Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Family and peer activities ☐ Ownership and competition ☐
Responsibility for self and family ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Money, allowance ☐
Promote mutual & self-respect ☐ Respect privacy ☐ Allow decisions ☐
Spend time with child talking, projects ☐

Play and communication: Organized sports ☐
Monitor TV and internet use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Masturbation ☐
Modesty ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmet ☐ Riding in traffic ☐
Smoke detector/escape plan ☐ Poison control # ☐ Water safety ☐
Protective devices in sports ☐ Alcohol/drug use ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Recommend objective Hearing and Vision Tests ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Testing for sickle cell trait if original metabolic results not available ☐
7. Dental visit advised ☐ or date of last visit_____
8. Next preventive appointment at _____
9. Referrals for identified problems: Yes / No *(specify)*_____

_____
_____
_____
_____

Signatures:_____

PEDIATRIC VISIT 14 TO 16 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? Yes / No_____

Family health history updated? Yes / No_____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*

Any fears of partner/other violence? Yes / No

Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No

Referral: Yes / No To:_____

RISK ASSESSMENT:

(Circle)	CHOL	TB	STI/HIV
	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____

Counseling provided? Yes / No _____

Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth (symptoms of eating disorders?) _____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

Nutritional Assessment:

Typical diet *(specify foods)*:

Symptoms of eating disorder? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Food sources of iron, calcium, folic acid ☐
Select healthy foods ☐ Prevent obesity ☐ Eat breakfast ☐
Avoid eating disorders/fad diets ☐ 2 hrs or less of TV/computer games ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Confidentiality ☐ Peer group pressures ☐ Mood swings ☐
Dependence vs. independence ☐ Establishing own values ☐
Social misconduct due to family dysfunctions ☐ Future plans ☐
Stay in school ☐ Love life ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Allow decisions ☐
Provide support, encouragement ☐ Money, allowance ☐
Promote mutual respect ☐ Respect privacy ☐

Health: Dental care ☐ Personal hygiene ☐ Fluoride ☐ Menstruation ☐
Breast/testicular self-exam ☐ Smoking ☐ Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Birth control ☐ STDs ☐
Sexual Responsibility ☐

Injury prevention: Seat belt ☐ Alcohol/drug use ☐ Bicycle helmets ☐
Protective devices in sports ☐ Water safety ☐
Smoke detector/escape plan ☐ Firearms (owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. PPD, if positive risk assessment ☐_____
3. Recommend Objective Hearing and Vision Tests ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Dental visit advised ☐ or date of last visit_____
7. Next preventive appointment at _____
8. Referrals for identified problems: Yes / No *(specify)*

_____

_____

_____

_____

Signatures:_____

PEDIATRIC VISIT 17 TO 20 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____

Family health history updated? _____

Reactions to immunizations? Yes / No_____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*

Any fears of partner/other violence? Yes / No

Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No

Referral: Yes / No To:_____

RISK ASSESSMENT:

	CHOL	TB	STI/HIV
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? No / Yes Counseling provided? No / Yes

Referral? No / Yes To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Symptoms of eating disorder? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Select healthy foods ☐ Use skim milk/and lowfat foods ☐

Avoid fad diets ☐ 2 hrs or less of TV/computer games ☐

5 fruits/vegetables daily ☐ No sweetened beverages ☐

Vitamin/mineral supplements, folic acid for females ☐ Eat breakfast ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School:

Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Love life ☐ Peer groups pressures ☐ Mood swings ☐

Social misconduct resulting from family dysfunctions ☐

Establishing own values ☐ Future plans ☐ Stay in school ☐

Parenting: Support ☐ Prepare for independence ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐

Second hand smoke ☐ Menstruation ☐ Breast/testicular self-exam ☐

Physical activity ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Birth control ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmets ☐

Protective devices in sports ☐ Smoke detector/escape plan ☐

Firearms (owner risk/safe storage) ☐ Alcohol/drug use ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐ _____
2. PPD if positive risk assessment ☐ _____
3. Testing/counseling if positive cholesterol risk assessment ☐_____
4. Testing if positive STD/HIV risk assessment ☐ _____
5. Dental visit advised ☐ or date of last visit ☐ _____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*

_____

_____

_____

_____

_____

_____

Signatures:_____

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

BMI Percentile Calculator for Child and Teen
English Version

This calculator provides BMI and the corresponding BMI-for-age percentile on a CDC BMI-for-age growth chart. Use this calculator for children and teens, aged 2 through 19 years old. For adults, 20 years old and older, use the Adult BMI Calculator (http://www.cdc.gov/healthyweight/assessing/bmi/adult_BMI/english_bmi_calculator/bmi_calculator.html).

Measuring Height and Weight Accurately At Home (http://www.cdc.gov/healthyweight/assessing/bmi/childrens_BMI/measuring_children.html)

BMI Calculator for Child and Teen

(English | Metric (Calculator.aspx?CalculatorType=Metric))

1. Birth Date:

Month ▾ Day ▾ Year ▾

2. Date of Measurement:

Month ▾ Day ▾ Year ▾

3. Sex:

○ Boy ○ Girl

4. Height, to nearest 1/8 inch:

Feet	Inches	Fractions of an inch
0 ▾	0 ▾	0 ▾

(12 inches = 1 foot; Example: 4 feet, 5 1/2 inches)

5. Weight, to nearest 1/4 (.25) pound:

Weight (pounds):	Fractions of a pound:
0	0 ▾

(8 ounces = 1/2 pounds; Example: 75 3/4 pounds)

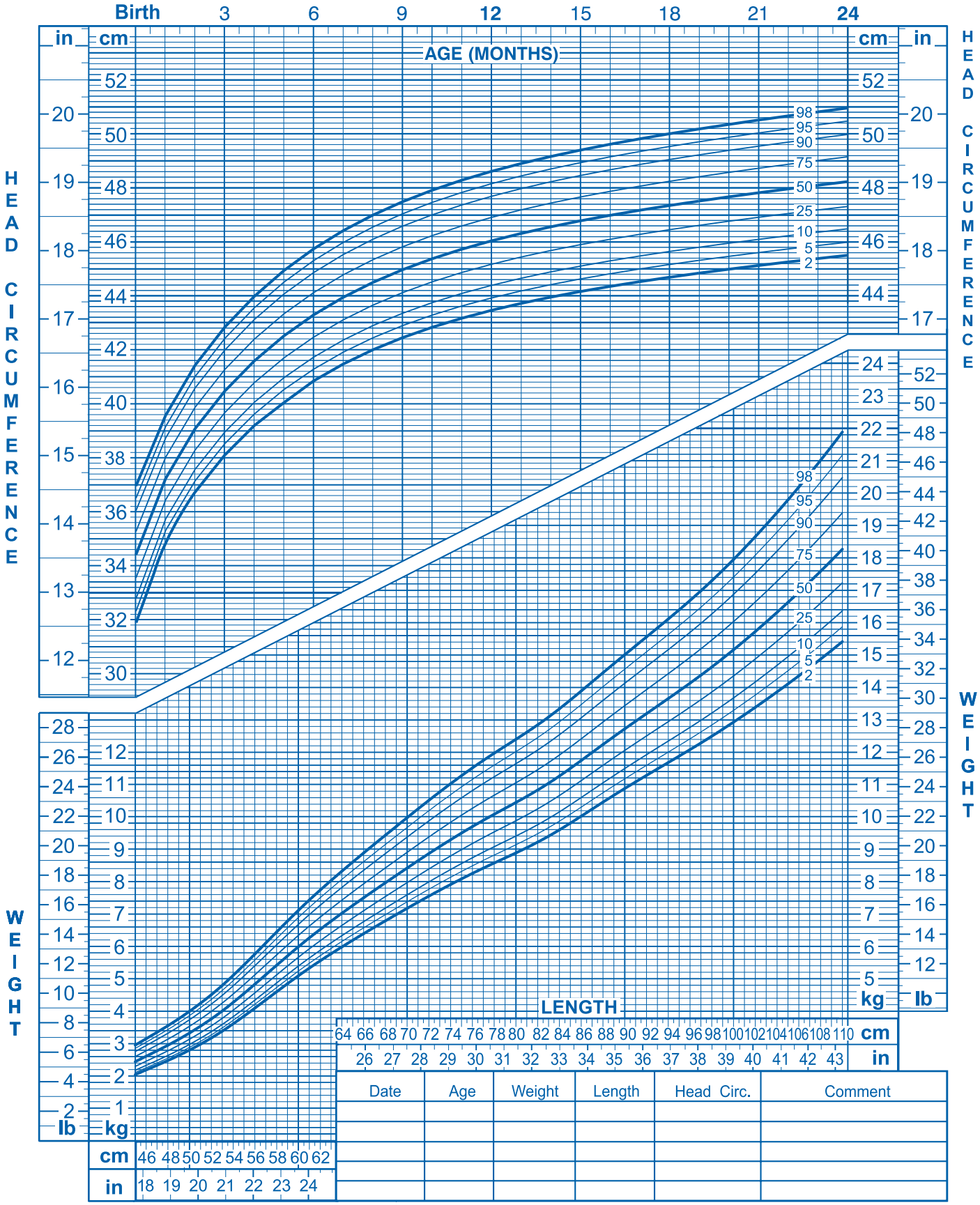
Calculate

Note: Please keep in mind that this BMI calculator is not meant to serve as a source of clinical guidance and is not intended to be a substitute for professional medical advice. Because BMI is based on weight and height, it is only an indicator of body fatness. Individuals with the same BMI may have different amounts of body fat. Persons may consider seeking advice from their health-care providers on healthy weight status and to consider individual circumstances.

Birth to 24 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



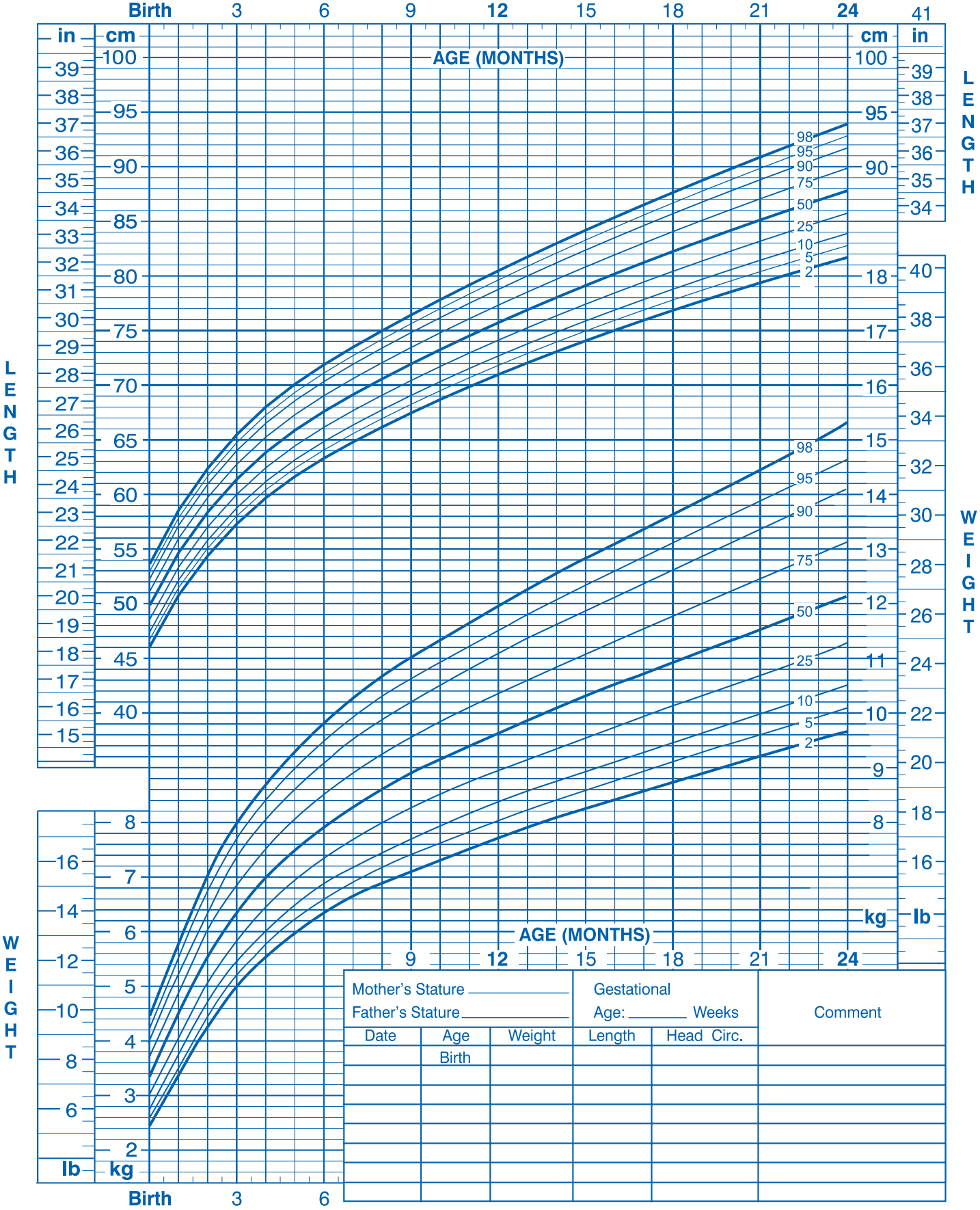
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational		Comment
Father's Stature _____			Age: _____ Weeks		
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

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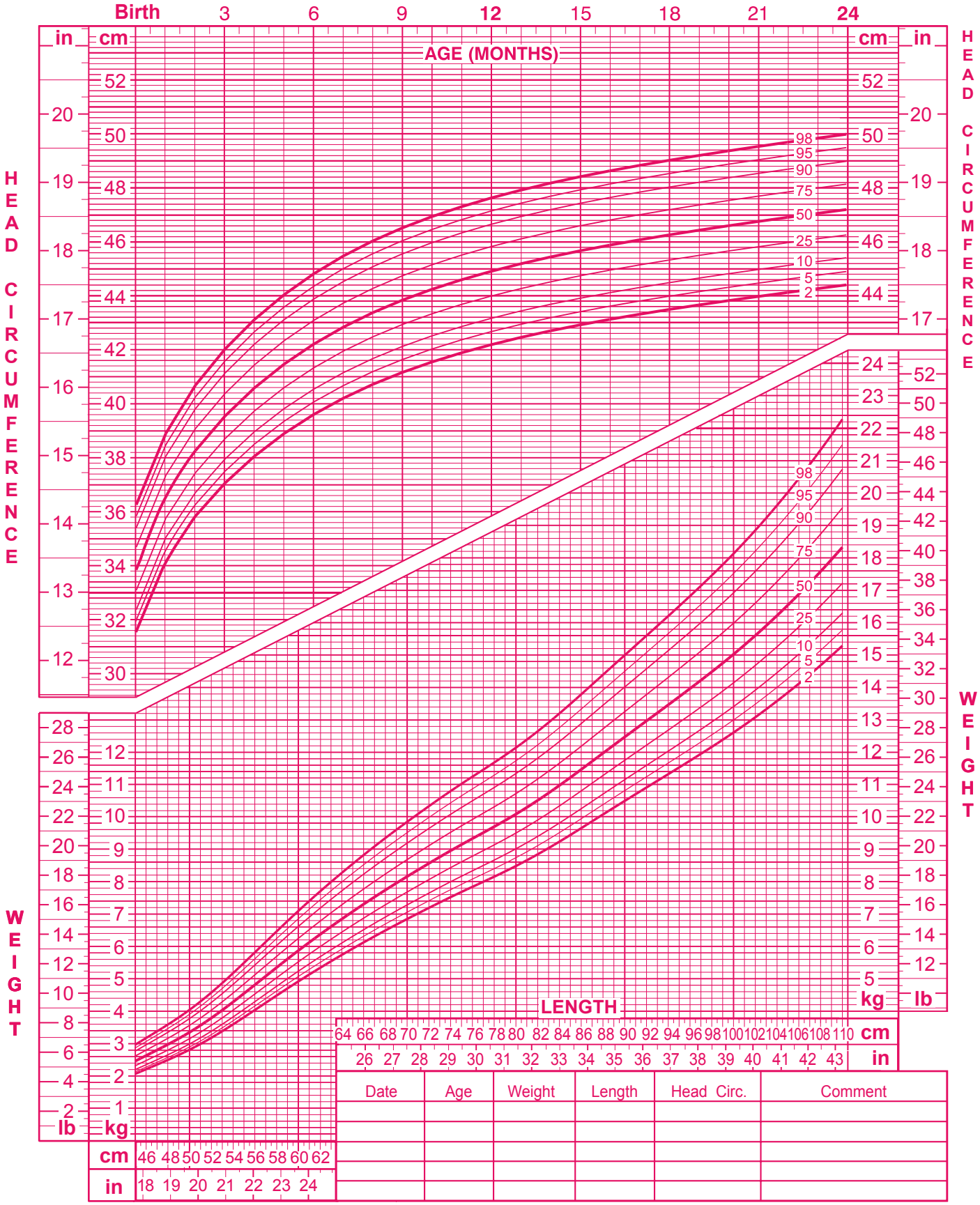
Birth to 24 months: Girls
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____

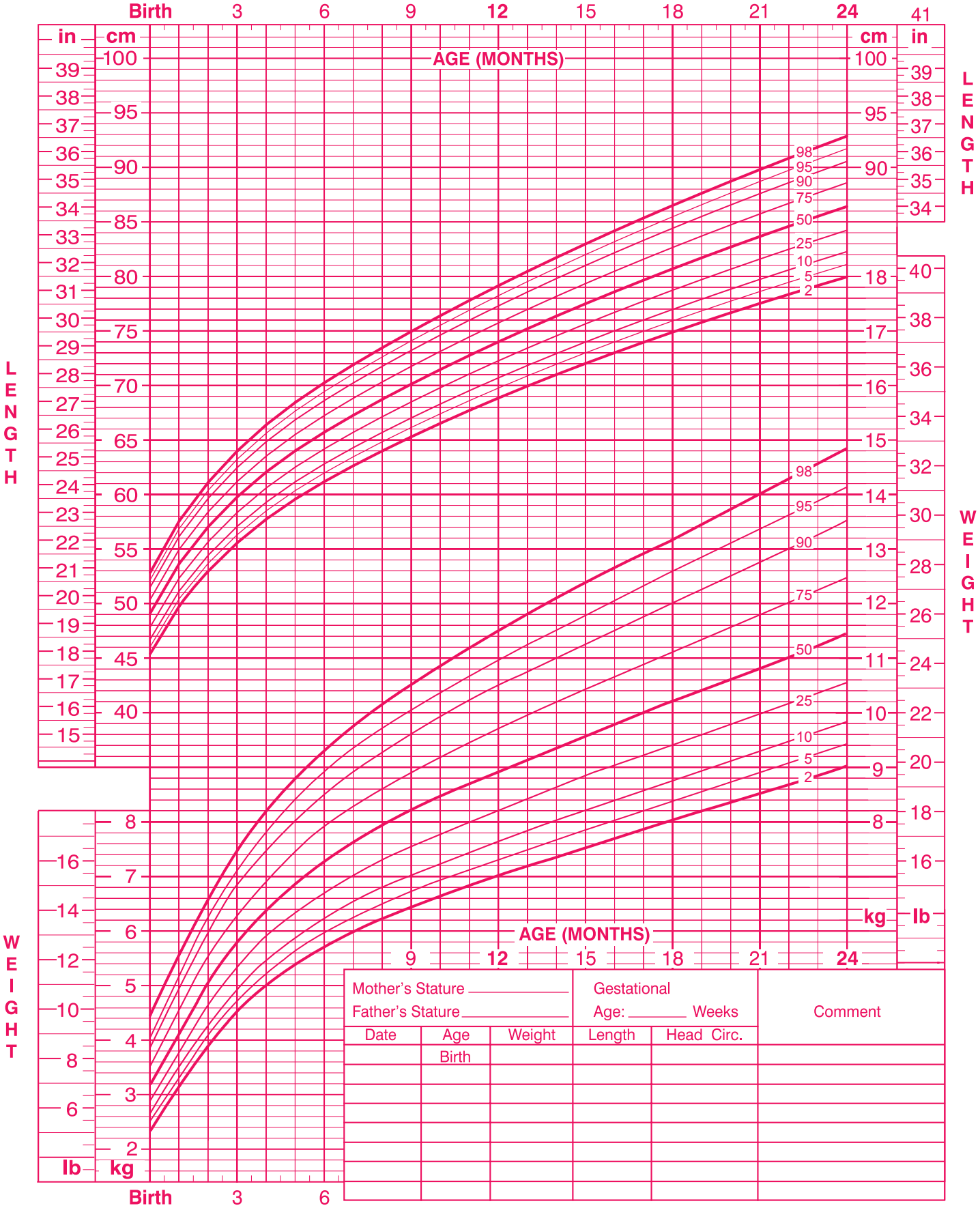


Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

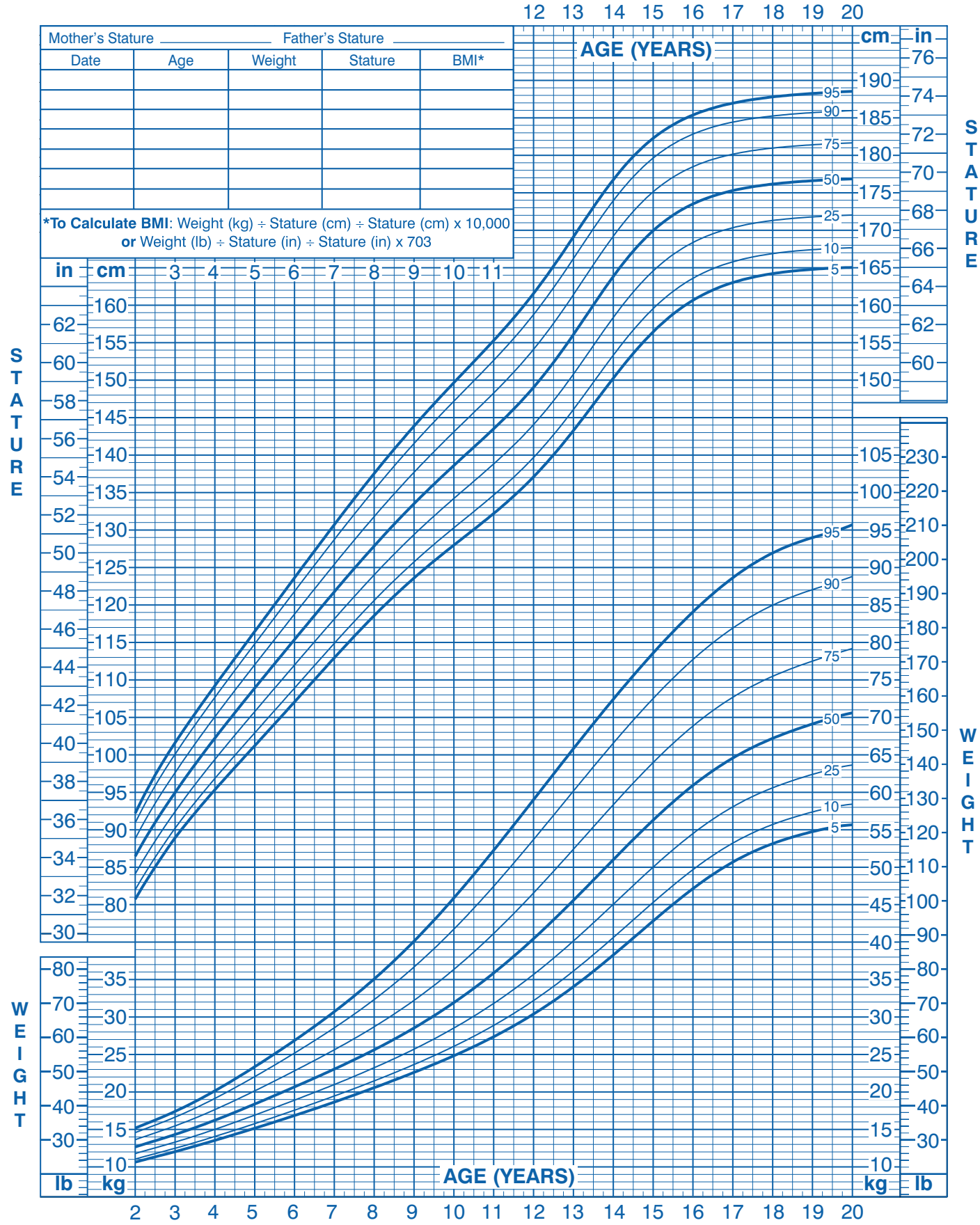
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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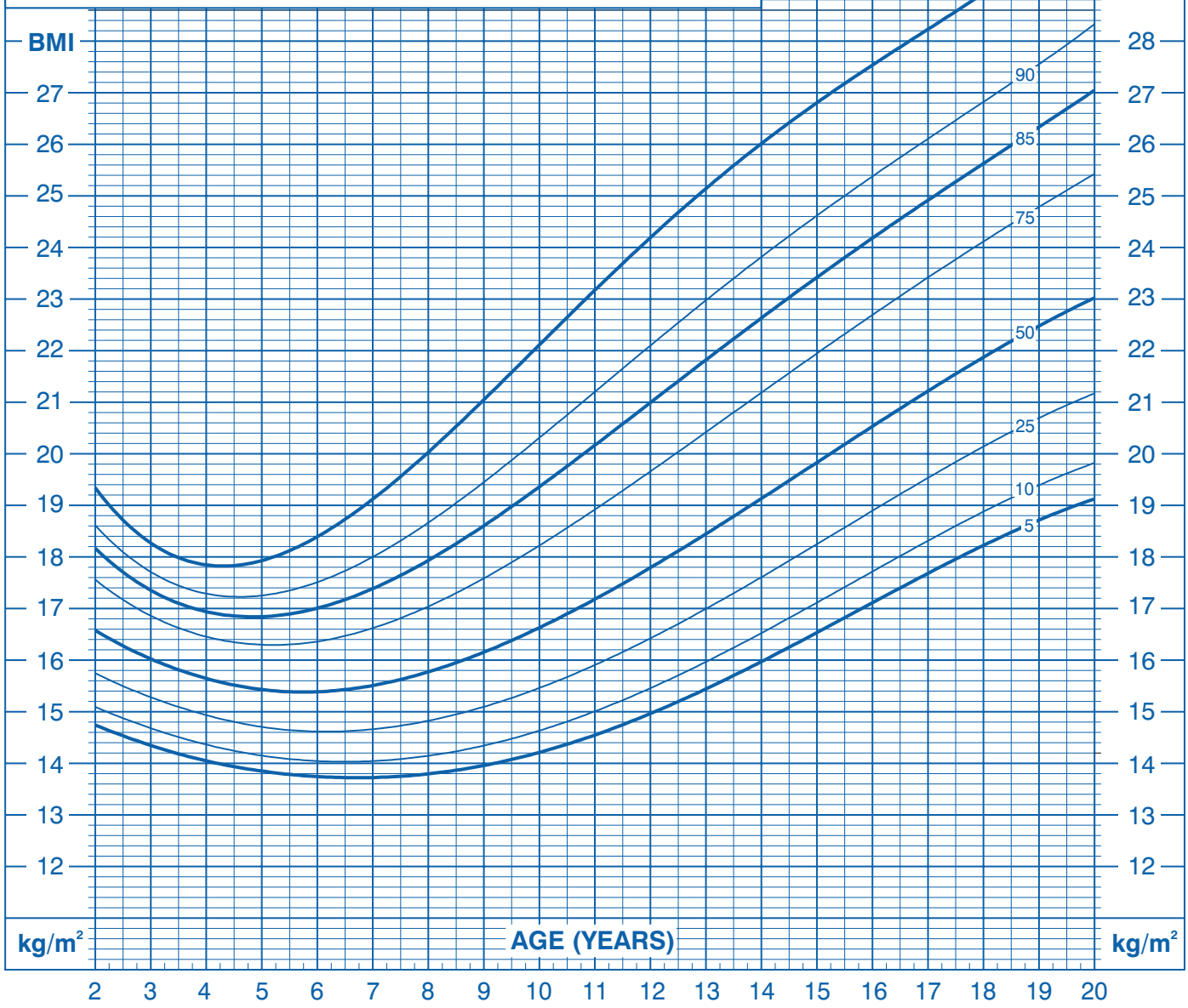
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

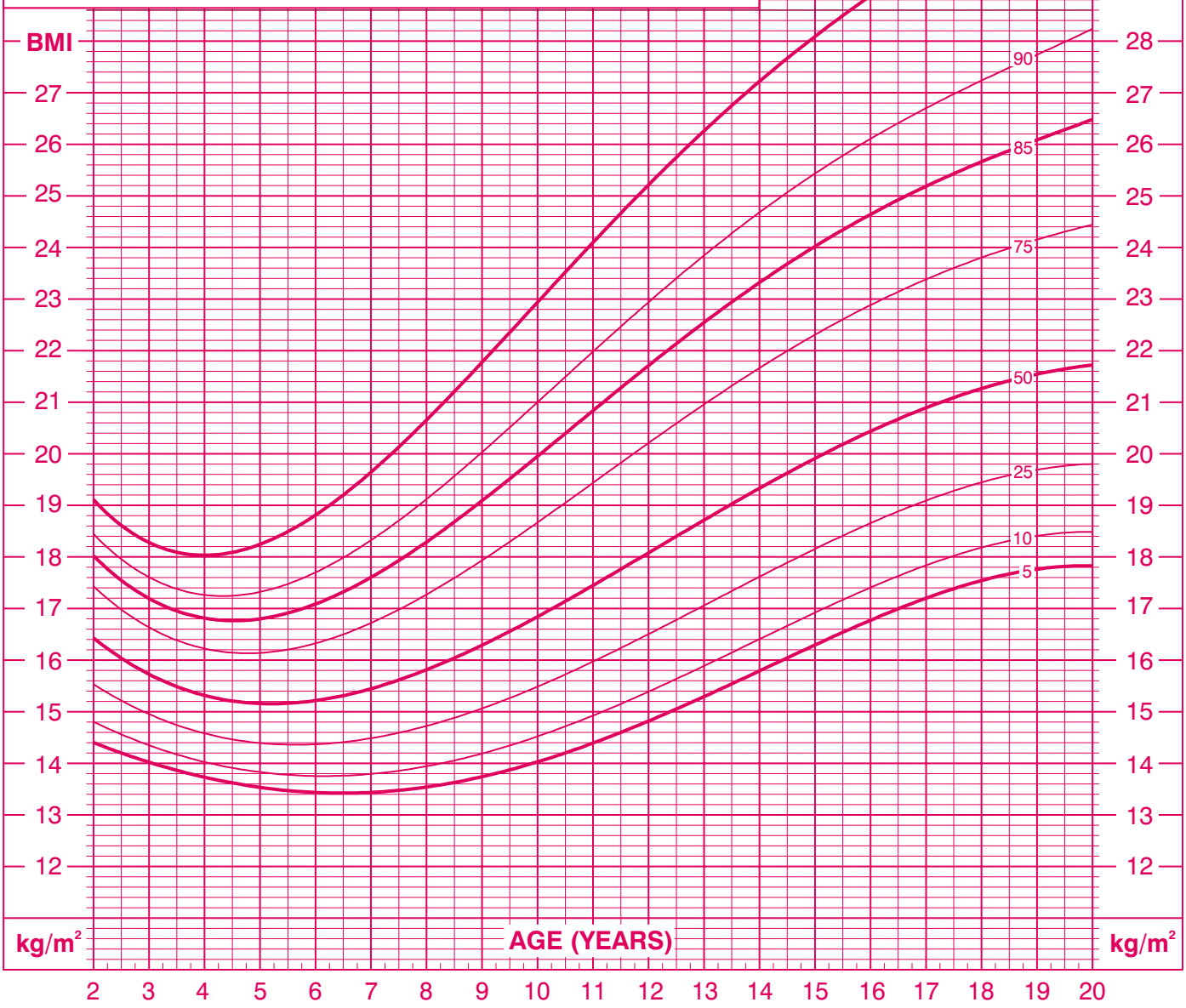
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

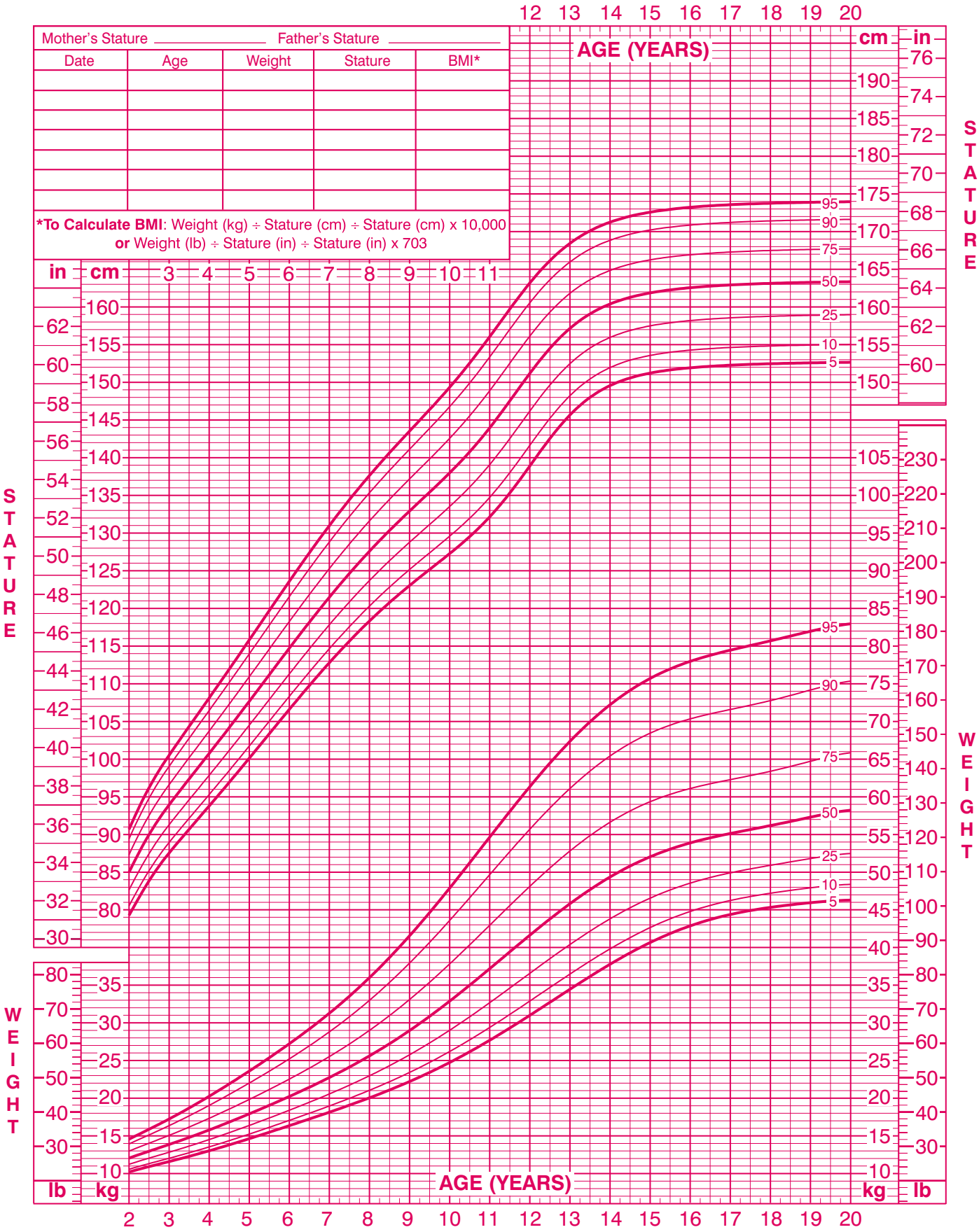
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

Maryland Healthy Kids Program

Cuestionario de Historial Médico Familiar

Nombre del Paciente:	**Fecha de Nacimiento:**	**Sexo: M F (circule)**
Persona que llenó el Formulario: / **Fecha de Hoy:**	**Relación con el Paciente::**	

HISTORIAL DURANTE EMBARAZO Y AL NACER

Nombre del Hospital: _____
Enfermedades durante el embarazo No ☐ Si☐
Medicamentos durante embarazo No ☐ Si☐
Abuso de Alcohol o drogas No ☐ Si☐
Problemas al Nacer No ☐ Si☐
Describa: _____
Tipo de Parto ☐ Vaginal ☐ Cesárea
Peso al Nacer_____**Peso al darle de alta**_____
El bebé recibió vacuna para Hepatitis B No☐ Si ☐
Fecha de la vacuna de Hepatitis B:_____
Examen Auditivo para recien nacidos No ☐ Si ☐

HISTORIAL PSICOSOCIAL

¿Quién vive en el hogar?_____
_____
¿Cuántas personas viven en el hogar?_____
☐ **Alquilan** ☐ **casa propia** ☐ **refugio**
¿Quién cuida el niño/a?_____
Fecha de Nacimiento Madre_____
Padre_____
Trabajan los Padres **Madre** No ☐ Si ☐
Padre No ☐ Si ☐
Hogar Sustituto _____**Fecha:**_____
¿Qué otro idiomas se hablan en la casa?_____
_____

HISTORIAL FAMILIAR

Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:

Alergias (a qué)			**¿Quién?**
_____	No ☐	Si ☐	_____
Asma	No ☐	Si ☐	_____
TB/Enfermedad del Pulmón	No ☐	Si ☐	_____
VIH/SIDA	No ☐	Si ☐	_____
Intentos Suicidas/Problemas	No ☐	Si ☐	_____
Mentales	No ☐	Si ☐	_____
Enfermedad del Corazón	No ☐	Si ☐	_____
Presión alta/Derrame	No ☐	Si ☐	_____
Colesterol Alto	No ☐	Si ☐	_____
Desórdenes de la	No ☐	Si ☐	_____
Sangre/"Sickle Cell"	No ☐	Si ☐	_____
Diabetes	No ☐	Si ☐	_____
Convulsiones	No ☐	Si ☐	_____
Alergias/Asma	No ☐	Si ☐	_____
Desórdenes Mentales	No ☐	Si ☐	_____
Cáncer	No ☐	SI ☐	_____
Defectos de Nacimiento	No ☐	Si ☐	_____
Pérdida de Audición	No ☐	Si ☐	_____
Problemas de habla	No ☐	Si ☐	_____
Enfermedades Renales	No ☐	Si ☐	_____
Abuso de Alcohol/ Droga	No ☐	Si ☐	_____
Hepatitis/Enfermedad del	No ☐	Si ☐	_____
Hígado	No ☐	Si ☐	_____
Enfermedad de la Tiroide	No ☐	Si ☐	_____
Problemas de Aprendizaje/	No ☐	Si ☐	_____
Deficit de Atención ("ADD")	No ☐	Si ☐	_____
Violencia Doméstica			
Otras:_____			

HISTORIAL DE SALUD

Alguna vez su niño/a ha tenido:

Alergias (a qué)_____		
Asma	No ☐	Si ☐
Varicela (año) _____	No ☐	Si ☐
Infecciones frecuentes de oído	No ☐	Si ☐
Problemas de Audición/Infecciones	No ☐	Si ☐
de la Vista	No ☐	Si ☐
Problemas de la Piel/Eczema	No ☐	Si ☐
Asma/Alergias	No ☐	Si ☐
TB/Enfermedad del Pulmón	No ☐	Si ☐
Convulsiones/Epilepsia	No ☐	Si ☐
Hipertensión/Presión Alta	No ☐	Si ☐
Enfermedad del Corazón/Defectos	No ☐	Si ☐
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐
Diabetes	No ☐	Si ☐
Enfermedades del Riñón/Vejiga	No ☐	Si ☐
Problemas Físicos o de Aprendizaje	No ☐	Si ☐
Desórdenes de la Sangre/Hemofilia	No ☐	Si ☐
Enfermedades Transmitidas		
Sexualmente	No ☐	Si ☐
Problemas Emocionales o de		
Comportamiento	No ☐	Si ☐
Depresión/Pensamientos Suicidas	No ☐	Si ☐
Hospitalizaciones/Cirugías	No ☐	Si ☐
Abuso /Físico/Emocional/ o Sexual	No ☐	Si ☐
Problemas en las Coyunturas/Huesos	No ☐	Si ☐
Obesidad/Trastornos Alimenticios	No ☐	Si ☐
Otras: _____		
Lista de Medicamento/s que		
toma:_____		

Revisado por:	**Fecha que fue Revisado:**

Updated: 4/06

OBJECTIVE HEARING AND VISION TESTING
MARYLAND HEALTHY KIDS PROGRAM

Child's Name:_____ Date of Birth_____

Objective Vision Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

Ages 3 – 6

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Vision Fusion:
Pass _____ Fail _____

Color Screens (optional):
Pass _____ Fail _____

Comments: _____

_____

Date of Service: _____

Screened by: _____

Ages 8 – 20

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Hyperopia:
Pass _____ Fail _____

Pass _____ Fail _____

Comments: _____

_____

.....

Objective Hearing Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____

Section 7 APPENDIX – II

Risk Assessments

CRAFFT Adolescent Substance Abuse Assessment - English & Spanish
Updated 2014

Mental Health Questionnaires - English &Spanish ***Updated 2014***

Nutrition Questionnaires - Infant, Child, Adolescent
Updated 2014

Preventive Screen Questionnaires: Tb, Lead, Cholesterol & STD/HIV - English & Spanish ***Updated 2016***

SEEK Parent Questionnaire (Abuse Assessment)- English & Spanish
Updated 2014

Victimization Scale - English & Spanish
Updated 2015

The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐
"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"		

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

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Las Preguntas CARLOS (CRAFFT)

Por favor responda a todas las preguntas con la mayor sinceridad posible;
sus respuestas serán tratadas de forma confidencial

Parte A

Durante los últimos doce meses:

	No	Sí
1. ¿Ha consumido bebidas alcohólicas (más de unos pocos sorbos)?	☐	☐
2. ¿Ha fumado marihuana o probado hachís?	☐	☐
3. ¿Ha usado algún otro tipo de sustancias que alteren su estado de ánimo o de conciencia? El término "algún otro tipo" se refiere a drogas ilícitas, medicamentos de venta libre o de venta con receta médica, así como a sustancias inhalables que alteren su estado mental.	☐	☐

Si respondió con un NO las tres primeras preguntas (A1, A2, A3), pase ahora a la pregunta **B1**

Si respondió con un SÍ a CUALQUIERA de las tres primeras preguntas (A1, A2, A3), pase ahora a las preguntas **B1 a B6**

Parte B (CARLOS)

	No	Sí
1. ¿Ha viajado, alguna vez, en un **CARRO** o vehículo conducido por una persona (o usted mismo/a) que haya consumido alcohol, drogas o sustancias psicoactivas?	☐	☐
2. ¿Le han sugerido, alguna vez, sus **AMIGOS o su familia** que disminuya el consumo de alcohol, drogas o sustancias psicoactivas?	☐	☐
3. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para **RELAJARSE**, para sentirse mejor consigo mismo o para integrarse a un grupo?	☐	☐
4. ¿Se ha metido, alguna vez, en **LÍOS** o problemas al tomar alcohol, drogas o sustancias psicoactivas?	☐	☐
5. ¿Se le ha **OLVIDADO,** alguna vez, lo que hizo mientras consumía alcohol, drogas o sustancias psicoactivas?	☐	☐
6. ¿Alguna vez ha consumido, alcohol, drogas o alguna sustancia psicoactiva mientras estaba **SOLO** o SOLA, sin compañía?	☐	☐

NOTA SOBRE EL CARÁCTER CONFIDENCIAL DE LA INFORMACIÓN
La información incluida en esta página puede estar protegida por normas federales sobre confidencialidad (42 CFR Parte 2) que prohíben su divulgación, a no ser que medie una autorización escrita para el caso específico. NO basta con que se cuente con una autorización generalizada en materia de divulgación de la información médica.

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MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 3 – 5 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often wet or soil his pants?.....☐ Yes ☐ No

Does your child have problems at day care or school? ..... ☐ Yes ☐ No

Do you have any concerns about your child:
- Daydreaming?..... ☐ Yes ☐ No
- Paying attention?..... ☐ Yes ☐ No
- Sitting still?..... ☐ Yes ☐ No

Does your child:
- Refuse to obey? ..... ☐ Yes ☐ No
- Refuse to play with others?..... ☐ Yes ☐ No

Does your child get tired easily? ..... ☐ Yes ☐ No

Does your child often seem:
- Sad?..... ☐ Yes ☐ No
- Angry?..... ☐ Yes ☐ No
- Nervous or afraid?..... ☐ Yes ☐ No
- Cranky?..... ☐ Yes ☐ No
- Not interested?..... ☐ Yes ☐ No

Does your child have trouble sleeping? ..... ☐ Yes ☐ No

Does your child have problems with eating? ..... ☐ Yes ☐ No

Is your child often mean to animals or smaller children? ..... ☐ Yes ☐ No

Is there a history of injuries, accidents? ..... ☐ Yes ☐ No
If yes, please specify: _____

Continued on Back →

MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

Page Two

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child? ..... ☐ Yes ☐ No
Moving? ..... ☐ Yes ☐ No
Divorce or separation? ..... ☐ Yes ☐ No
Death of a close relative? ..... ☐ Yes ☐ No
Fired or laid off? ..... ☐ Yes ☐ No
Legal problems? ..... ☐ Yes ☐ No
Others (Please specify): _____

Do you have other parenting concerns? ..... ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____
Child's Address: _____
Child's Phone: _____
Referred to: **MD Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____Date of Birth: _____

Managed Care Organization: _____ Child's Medicaid #: _____

Ages 6 – 9 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often seem:
- Distrustful of others? ..... ☐ Yes ☐ No
- Have trouble paying attention? ..... ☐ Yes ☐ No
- Blame others? ..... ☐ Yes ☐ No

Do you have concerns about your child's:
- Eating? ..... ☐ Yes ☐ No
- Sleep? ..... ☐ Yes ☐ No
- Weight? ..... ☐ Yes ☐ No

Does your child often complain of "not feeling well"? ..... ☐ Yes ☐ No

Does your child have problems getting along with:
- Parent(s)? ..... ☐ Yes ☐ No
- Other family members?..... ☐ Yes ☐ No
- Friends? ..... ☐ Yes ☐ No
- School mates? ..... ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior? ..... ☐ Yes ☐ No
- Grades? ..... ☐ Yes ☐ No
- Not wanting to go to school? ..... ☐ Yes ☐ No

Does your child often seem:
- Sad? ..... ☐ Yes ☐ No
- Angry? ..... ☐ Yes ☐ No
- Nervous or afraid? ..... ☐ Yes ☐ No
- Cranky? ..... ☐ Yes ☐ No
- Not interested? ..... ☐ Yes ☐ No

Does your child often:
- Destroy property? ..... ☐ Yes ☐ No
- Lie? ..... ☐ Yes ☐ No
- Steal? ..... ☐ Yes ☐ No
- Hurt animals or smaller children? ..... ☐ Yes ☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Page Two

Is there a history of injuries, accidents? …….. ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? …… ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

- Birth of a child?…… ☐ Yes ☐ No
- Moving?…… ☐ Yes ☐ No
- Divorce or separation? …… ☐ Yes ☐ No
- Death of a close relative?…….. ☐ Yes ☐ No
- Fired or laid off?…… ☐ Yes ☐ No
- Legal problems?…… ☐ Yes ☐ No
- Others (Please specify): _____

Do you have other parenting concerns?…… ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date

Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

_____

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 10 – 12 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child have trouble paying attention? ..... ☐ Yes ☐ No

Does your child often seem:
- Distrustful of others? ..... ☐ Yes ☐ No
- To express strange thoughts?..... ☐ Yes ☐ No
- Blame others? ..... ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior?..... ☐ Yes ☐ No
- Grades? ..... ☐ Yes ☐ No
- Skipping classes?..... ☐ Yes ☐ No

Do you have concerns about your child's:
- Eating? ..... ☐ Yes ☐ No
- Sleep? ..... ☐ Yes ☐ No
- Weight? ..... ☐ Yes ☐ No

Does your child often complain of "not feeling well"? ..... ☐ Yes ☐ No

Does your child have trouble making or keeping friends? ..... ☐ Yes ☐ No

Does your child often seem:
- Sad? ..... ☐ Yes ☐ No
- Angry?..... ☐ Yes ☐ No
- Nervous or afraid?..... ☐ Yes ☐ No

Does your child show any of these behaviors?
- Destroy property? ..... ☐ Yes ☐ No
- Set fire? ..... ☐ Yes ☐ No
- Lie? ..... ☐ Yes ☐ No
- Steal? ..... ☐ Yes ☐ No
- Listen to music with violent message? ..... ☐ Yes ☐ No
- Hurt animal or smaller children? ..... ☐ Yes ☐ No
- Use alcohol? ..... ☐ Yes ☐ No
- Use drugs?..... ☐ Yes ☐ No
- Smoke cigarettes? ..... ☐ Yes ☐ No
- Sexually active? ..... ☐ Yes ☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Page Two

Is there a history of injuries, accidents? …….. ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? …… ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

- Birth of a child ……. ☐ Yes ☐ No
- Moving …… ☐ Yes ☐ No
- Divorce or separation …… ☐ Yes ☐ No
- Death of a close relative …….. ☐ Yes ☐ No
- Fired or laid off …… ☐ Yes ☐ No
- Legal problems …… ☐ Yes ☐ No
- Others (Please specify): _____

Do you have other parenting concerns? …… ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

_____

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 13 – 20 years

Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.

Do you have trouble paying attention? ..... ☐ Yes ☐ No

Do you often:
- Feel distrustful of others? ..... ☐ Yes ☐ No
- Have strange thoughts? ..... ☐ Yes ☐ No
- Hear voices? ..... ☐ Yes ☐ No
- Have to do things the same way or keep repeating them? ..... ☐ Yes ☐ No

Do you have problems at school with:
- Behavior? ..... ☐ Yes ☐ No
- Grades? ..... ☐ Yes ☐ No
- Skipping classes? ..... ☐ Yes ☐ No

Do you worry about your:
- Eating? ..... ☐ Yes ☐ No
- Sleep? ..... ☐ Yes ☐ No
- Weight? ..... ☐ Yes ☐ No

Do you have trouble making or keeping friends? ..... ☐ Yes ☐ No

Do you often feel:
- Sad? ..... ☐ Yes ☐ No
- Angry? ..... ☐ Yes ☐ No
- Nervous or afraid? ..... ☐ Yes ☐ No

Have you thought about or done any of the following:
- Destroy property? ..... ☐ Yes ☐ No
- Hurt animals? ..... ☐ Yes ☐ No
- Set fire? ..... ☐ Yes ☐ No
- Listen to music with violent message? ..... ☐ Yes ☐ No
- Use alcohol? ..... ☐ Yes ☐ No
- Use drugs? ..... ☐ Yes ☐ No
- Smoke cigarettes? ..... ☐ Yes ☐ No
- Sex without protection? ..... ☐ Yes ☐ No
- Suicide attempt? ..... ☐ Yes ☐ No

Continued on back ⟶

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Page Two

Is there a history of injuries, accidents? …….. ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? …… ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as :

- Birth of a child? …… ☐ Yes ☐ No
- Moving? …… ☐ Yes ☐ No
- Divorce or separation? …… ☐ Yes ☐ No
- Death of a close relative? …….. ☐ Yes ☐ No
- Fired or laid off? …… ☐ Yes ☐ No
- Legal problems? …… ☐ Yes ☐ No
- Others (Please specify): _____

Do you have other parenting concerns? …… ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

_____

MARYLAND HEALTHY KIDS PROGRAM
Maryland Department of Health and Mental Hygiene HealthChoice and Acute Care Administration, Division of Children's Services

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL
Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

Edades 3 – 5

Marque todas las respuestas que apliquen. Este formulario puede ser completado por el padre / encargado o por el proveedor de cuidados médicos.

¿Su niño moja o ensucia los pantalones con frecuencia? …… ☐ Si ☐ No

¿Su niño tiene problemas en el centro de cuido o en la escuela?…….... ☐ Si ☐ No

¿Le preocupa que su hijo:
- Sueñe despierto?……...…… ☐ Si ☐ No
- No preste atención?…….. ☐ Si ☐ No
- No se mantenga quieto?…….…….. ☐ Si ☐ No

¿Su niño:
- Se niega a obedecer?……..……. ☐ Si ☐ No
- Se niega a jugar con otros?…….……..... ☐ Si ☐ No

¿Se cansa fácilmente?…….....…….……..……... ☐ Si ☐ No

¿Con frecuencia su niño parece estar:
- Triste?…….…….…… ☐ Si ☐ No
- Con coraje?…….…… ☐ Si ☐ No
- Nervioso o asustado?……..…… ☐ Si ☐ No
- Molesto?…….…….…… ☐ Si ☐ No
- Desinteresado?……..……... ☐ Si ☐ No

¿Su niño tiene dificultad al dormir?..……..…….… ☐ Si ☐ No

¿Su niño tiene problemas para comer?..……... ☐ Si ☐ No

¿Con frecuencia, su niño es cruel con los animales o con niños más pequeños?..... ☐ Si ☐ No

¿Existe historial de accidentes o lesiones?....…….……... ☐ Si ☐ No
Si existe, por favor especifique:_____

(Continúa por detrás)

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

¿Existe algún historial de abuso o maltrato?…..…….....…. ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Ha habido algún cambio reciente que haya sido drástico dentro de la familia del niño como:

El nacimiento de otro niño?……..……..……. ☐ Si ☐ No
Mudanza?…….…… ☐ Si ☐ No
Divorcio o separación?……..... ☐ Si ☐ No
Muerte de algún familiar cercano?……..... ☐ Si ☐ No
Renuncia o despido de empleo?……..... ☐ Si ☐ No
Problemas legales?…….……..……..... ☐ Si ☐ No
Otros (por favor especifique)_____

¿Tiene alguna otra preocupación relacionada con la crianza de este niño?..... ☐ Si ☐ No
Por favor especifique_____

Proveedor: Explique dando detalles todas las contestaciones **afirmativas** que haya obtenido.

_____ _____
Firma del Proveedor Fecha

Número de Teléfono del Proveedor (_ _ _) _ _ _ / _ _ _ _

ESTE FORMULARIO PUEDE SER USADO PARA REFERIDOS DE SALUD MENTAL

El niño que recibió el referido: _____

Dirección del niño: _____

Número de teléfono del niño: _____

Referido a: _____

Razón del referido: _____

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

Edades 6 – 9

Marque todas las respuestas que apliquen. Este formulario puede ser completado por el padre / encargado o por el proveedor de cuidados médicos.

¿Su niño con frecuencia aparenta:

- Desconfiar de otros?…….…… ☐ Si ☐ No
- Tener dificultad prestando atención?……..... ☐ Si ☐ No
- Culpar a otros?……..……,……..…… ☐ Si ☐ No

¿Usted tiene preocupación por su niño al:

- Comer?…….…… ☐ Si ☐ No
- Dormir?……..…… ☐ Si ☐ No
- Pesarlo?…….…… ☐ Si ☐ No

¿Con frecuencia su niño se queja de no sentirse bien?…….…….. ☐ Si ☐ No

¿Su niño tiene problemas relacionándose con:

- Padres?……..……..... ☐ Si ☐ No
- Otros miembros de la familia?……..…… ☐ Si ☐ No
- Amigos?…….……... ☐ Si ☐ No
- Compañeros de la escuela?…….. ☐ Si ☐ No

¿Su niño tiene problemas en la escuela con:

- Comportamiento?…… ☐ Si ☐ No
- Calificaciones?……...…….. ☐ Si ☐ No
- No desear ir a la escuela?…….. ☐ Si ☐ No

¿Con frecuencia su niño aparentar estar:

- Triste?…….……... ☐ Si ☐ No
- Con coraje?…….…….. ☐ Si ☐ No
- Nervioso o asustado?……..…… ☐ Si ☐ No
- Molesto?…….…… ☐ Si ☐ No
- Desinteresado?……...……...…….. ☐ Si ☐ No

¿Con frecuencia su niño:

- Destruye la propiedad ajena?…… ☐ Si ☐ No
- Miente?…….…… ☐ Si ☐ No
- Roba?…….…… ☐ Si ☐ No
- Lastima niños más pequeños o animales?……..…… ☐ Si ☐ No

(Continúa por detrás)

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

¿Existe historial de accidentes o lesiones?.....……..... ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Existe algún historial de abuso o maltrato?…...…….....…... ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Ha habido algún cambio reciente que haya sido drástico dentro de la familia del niño como:

- El nacimiento de otro niño?……..... ☐ Si ☐ No
- Mudanza?…….....……..... ☐ Si ☐ No
- Divorcio o separación?…….…..... ☐ Si ☐ No
- Muerte de algún familiar cercano?……..……..... ☐ Si ☐ No
- Renuncia o despido de empleo?….....……..... ☐ Si ☐ No
- Problemas legales?…….…..... ☐ Si ☐ No
- Otros (por favor especifique)_____

¿Tiene alguna otra preocupación relacionada con la crianza de este niño?.....…..... ☐ Si ☐ No
Por favor especifique_____

Proveedor: Explique dando detalles todas las contestaciones **afirmativas** que haya obtenido.

_____ _____
Firma del Proveedor Fecha

Número de Teléfono del Proveedor (_ _ _) _ _ _ / _ _ _ _

ESTE FORMULARIO PUEDE SER USADO PARA REFERIDOS DE SALUD MENTAL

El niño que recibió el referido: _____

Dirección del niño: _____

Número de teléfono del niño: _____

Referido a: _____

Razón del referido: _____

MARYLAND HEALTHY KIDS PROGRAM
Maryland Department of Health and Mental Hygiene
HealthChoice and Acute Care Administration, Division of Children's Services

https://mmcp.dhmh.maryland.gov/epsdt **2014**

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

Edades 10 – 12

Marque todas las respuestas que apliquen. Este formulario puede ser completado por el padre / encargado o por el proveedor de cuidados médicos.

¿Su niño tiene dificultad poniendo atención?..... ☐ Si ☐ No

¿Con frecuencia su niño parece:
- Desconfiar de otros?..... ☐ Si ☐ No
- Expresar pensamientos extraños?..... ☐ Si ☐ No
- Culpar a otros?..... ☐ Si ☐ No

¿Su niño tiene problemas en la escuela:
- Con comportamiento?..... ☐ Si ☐ No
- Con calificaciones?..... ☐ Si ☐ No
- Cortando clases?..... ☐ Si ☐ No

¿Usted tiene preocupación por su niño al:
- Comer?..... ☐ Si ☐ No
- Dormir?..... ☐ Si ☐ No
- Pesarlo?..... ☐ Si ☐ No

¿Su niño se queja con frecuencia de no sentirse bien?..... ☐ Si ☐ No

¿Su niño tiene dificultad haciendo o manteniendo amigos?..... ☐ Si ☐ No

¿Con frecuencia su niño aparenta estar:
- Triste?..... ☐ Si ☐ No
- Con coraje?..... ☐ Si ☐ No
- Nervioso o asustado?..... ☐ Si ☐ No

¿Su niño demuestra alguno de estos comportamientos:
- Destruye la propiedad ajena?..... ☐ Si ☐ No
- Comienza incendios?..... ☐ Si ☐ No
- Miente?..... ☐ Si ☐ No
- Roba?..... ☐ Si ☐ No
- Escucha música con mensajes violentos?..... ☐ Si ☐ No
- Lastima niños más pequeños o animales?..... ☐ Si ☐ No
- Usa alcohol?..... ☐ Si ☐ No
- Usa drogas?..... ☐ Si ☐ No
- Fuma cigarrillos?..... ☐ Si ☐ No
- Esta sexualmente activo?..... ☐ Si ☐ No

(Continúa por detrás)

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

¿Existe historial de accidentes o lesiones?.....……..……..... ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Existe algún historial de abuso o maltrato?…...…….....…….. ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Ha habido algún cambio reciente que haya sido drástico dentro de la familia del niño como:

- El nacimiento de otro niño?……..…….……..... ☐ Si ☐ No
- Mudanza?…….....…… ☐ Si ☐ No
- Divorcio o separación?……..... ☐ Si ☐ No
- Muerte de algún familiar cercano?…….……..... ☐ Si ☐ No
- Renuncia o despido de empleo?……..……..... ☐ Si ☐ No
- Problemas legales?……..... ☐ Si ☐ No
- Otros (por favor especifique)_____

¿Tiene alguna otra preocupación relacionada con la crianza de este niño?..... ☐ Si ☐ No
Por favor especifique_____

Proveedor: Explique dando detalles todas las contestaciones **afirmativas** que haya obtenido.

_____ _____
Firma del Proveedor Fecha

Número de Teléfono del Proveedor (_ _ _) _ _ _ / _ _ _ _

ESTE FORMULARIO PUEDE SER USADO PARA REFERIDOS DE SALUD MENTAL

El niño que recibió el referido: _____

Dirección del niño: _____

Número de teléfono del niño: _____

Referido a: _____

Razón del referido: _____

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

Edades 13 – 20

Marque todas las respuestas que apliquen. Este formulario puede ser completado por el paciente, padre / encargado o por el proveedor de cuidados médicos.

¿Tienes dificultad poniendo atención?..... ☐ Si ☐ No

¿Con frecuencia:

- Desconfías de otros?..... ☐ Si ☐ No
- Tienes pensamientos extraños?..... ☐ Si ☐ No
- Escuchas voces?..... ☐ Si ☐ No
- Tienes que hacer las cosas de la misma manera o sigues repitiéndolas?..... ☐ Si ☐ No

¿Tienes problemas en la escuela:

- Con Comportamiento?..... ☐ Si ☐ No
- Con Calificaciones?..... ☐ Si ☐ No
- Cortando clases?..... ☐ Si ☐ No

¿Te preocupas por:

- Comer?..... ☐ Si ☐ No
- Dormir?..... ☐ Si ☐ No
- Tu peso?..... ☐ Si ☐ No

¿Tienes dificultad haciendo o manteniendo amistades? ..... ☐ Si ☐ No

¿Con frecuencia te sientes:

- Triste?..... ☐ Si ☐ No
- Con coraje?..... ☐ Si ☐ No
- Nervioso o asustado?..... ☐ Si ☐ No

¿Has pensado o has hecho alguna de las siguientes cosas:

- Destruir propiedad ajena?..... ☐ Si ☐ No
- Lastimar a animales?..... ☐ Si ☐ No
- Comenzar incendios?..... ☐ Si ☐ No
- Escuchar música con mensajes violentos?..... ☐ Si ☐ No
- Usar alcohol?..... ☐ Si ☐ No
- Usar drogas?..... ☐ Si ☐ No
- Fumar cigarrillos?..... ☐ Si ☐ No
- Sexo sin protección?..... ☐ Si ☐ No
- Atentar suicidio?..... ☐ Si ☐ No

(Continúa por detrás)

CUESTIONARIO PARA BIENESTAR DE SALUD MENTAL

Niños Saludables/Healthy Kids

Fecha_____

Nombre del Niño:_____ **Fecha de Nacimiento:**_____

¿Existe historial de accidentes o lesiones? ……..... ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Existe algún historial de abuso o maltrato? ……..... ☐ Si ☐ No
Si existe, por favor especifique:_____

¿Ha habido algún cambio reciente que haya sido drástico dentro de la familia del niño como:

- El nacimiento de otro niño?…….……..... ☐ Si ☐ No
- Mudanza?…….…….....…… ☐ Si ☐ No
- Divorcio o separación? ……..... ☐ Si ☐ No
- Muerte de algún familiar cercano? ……..... ☐ Si ☐ No
- Renuncia o despido de empleo? ……...……..... ☐ Si ☐ No
- Problemas legales? ……..... ☐ Si ☐ No
- Otros (por favor especifique)_____

¿Tiene alguna otra preocupación relacionada con la crianza de este niño?.....……..... ☐ Si ☐ No
Por favor especifique_____

Proveedor: Explique dando detalles todas las contestaciones **afirmativas** que haya obtenido.

_____ _____
Firma del Proveedor Fecha

Número de Teléfono del Proveedor (_ _ _) _ _ _ / _ _ _ _

ESTE FORMULARIO PUEDE SER USADO PARA REFERIDOS DE SALUD MENTAL

El niño que recibió el referido: _____

Dirección del niño: _____

Número de teléfono del niño: _____

Referido a: _____

Razón del referido: _____

NUTRITION QUESTIONNAIRE FOR INFANTS

1. How would you describe feeding time with your baby?
(Check all that apply.)

- ☐ Always pleasant
- ☐ Usually pleasant
- ☐ Sometimes pleasant
- ☐ Never pleasant

2. How do you know when your baby is hungry or has had enough to eat?

3 What type of milk do you feed your baby and how often?
(Check all that apply.)

- ☐ Iron-fortified infant formula
- ☐ Evaporated milk
- ☐ Whole milk
- ☐ Reduced-fat (2%) milk
- ☐ Low-fat (1%) milk
- ☐ Fat-free (skim) milk
- ☐ Goat's milk
- ☐ Soymilk

4. What types of things can your baby do?
(Check all that apply.)

- ☐ Open mouth for breast or bottle
- ☐ Drink liquids
- ☐ Follow objects and sounds with eyes
- ☐ Put hand in mouth
- ☐ Sit with support
- ☐ Bring objects to mouth and bite them
- ☐ Hold bottle without support
- ☐ Drink from a cup that is held

5. Does your baby eat solid foods? If yes, which ones?

NUTRITION QUESTIONNAIRE FOR INFANTS

6. Does your baby drink juice? If yes, how much?

7. Does your baby take a bottle to bed at night or carry a bottle around during the day?

8. Do you add honey to your baby's bottle or dip your baby's pacifier in honey?

9. What is the source of the water your baby drinks? Sources include public, well, commercially bottled, and home system-processed water.

10. Do you have a working stove, oven, and refrigerator where you live?

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. What concerns or questions do you have about feeding your baby or how your baby is growing? Do you have any concerns or questions about your baby's weight?

NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10

1. How would you describe your child's appetite?
- ☐ Fair
- ☐ Good
- ☐ Poor

2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?
- ☐ Always pleasant
- ☐ Usually pleasant
- ☐ Sometimes pleasant
- ☐ Never pleasant

4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week? (*Check all that apply*)

Grains:
- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:……..

Vegetables
- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables……

Fruits
- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice
- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/ juice:……

Milk and Milk Products
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: ……..

Meal and Meal Alternatives
- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/ deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:……

Fats and Sweets
- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Soft drinks
- ☐ Pies
- ☐ Other fats and sweets: ……

NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10

6. If your child is 5 years or younger, does
he or she eat any of these foods?
(*Check all that apply*.)

- ☐ Hot dogs
- ☐ Marshmallows
- ☐ Nuts and seeds
- ☐ Peanut butter
- ☐ Popcorn
- ☐ Pretzels and chips
- ☐ Raisins
- ☐ Raw celery or carrots
- ☐ Hard or chewy candy
- ☐ Whole grapes

7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?

8. Does your child take a bottle to bed at night or carry a bottle around during the day?

☐ Yes ☐ No

9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?

10. Do you have a working stove, oven, and refrigerator where you live?

☐ Yes ☐ No

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?

☐ Yes ☐ No

If yes, on how many days and for how many minutes or hours per day?.....

13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games:

☐ Yes ☐ No

If yes, how many hours per day?.....

14. Does your family watch television during meals?

☐ Yes ☐ No

15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

1. Which of these meals or snacks did you eat yesterday?
(*Check all that apply*)

- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner or supper
- ☐ Morning snack
- ☐ Afternoon Snack
- ☐ Evening/late-snack

2. Do you skip breakfast 3 or more times a week?

☐ Yes ☐ No

Do you skip lunch 3 or more times a week?

☐ Yes ☐ No

Do you skip dinner or supper 3 or more times a week?

☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?

☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?

☐ Yes ☐ No

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?

☐ Yes ☐ No

6. Are you on special diet for medical reasons?

☐ Yes ☐ No

7. Are you a vegetarian?

☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?

☐ Yes ☐ No

9. Which of the following did you drink last week?*(Check all that apply)*

- ☐ Tap or bottled water
- ☐ Fitness water
- ☐ Juice
- ☐ Regular soft drinks
- ☐ Diet soft drinks
- ☐ Fruit-flavored drinks
- ☐ Sport drinks
- ☐ Energy drinks
- ☐ Recovery drinks
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk (for example, chocolate, strawberry)
- ☐ Coffee or tea
- ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat last week?
(*Check all that apply*)

Grains:

- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:……..

Vegetables

- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables……

Fruits

- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice

- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/juice:……

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: ……

Meal and Meal Alternatives

- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:……

Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Pies
- ☐ Soft drinks
- ☐ Other fats and sweets: ……..

11. Do you have a working stove, oven, and refrigerator where you live?
☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
☐ Yes ☐ No

13. Are you concerned about your weight?
☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?
☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
☐ Yes ☐ No
If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
☐ Yes ☐ No
If yes, how many hours per day?.....

18. Does the family watch television during meals?
☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?
☐ Yes ☐ No

21. Do you ever use any of the following?
(Check all that apply)

- ☐ Alcohol, beer, or wine
- ☐ Steroids (without a doctor's permission)
- ☐ Street drugs (marihuana, speed, crack, or heroin)

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Tuberculosis Risk Assessment: *(Starting at 1 month of age and annually thereafter)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child been exposed to anyone with a case of TB **or** a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Anemia Screening (Starting at 11 years of age and annually thereafter)	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____**Birth Date:** _____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment: *(2 years through 20 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment: *(11 years through 20 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____**Birth Date:** _____

Programa para Niños Saludables de Maryland (Maryland Healthy Kids Program)
Cuestionario de Detección Temprana

Evaluación sobre riesgo de Plomo (envenenamiento con Plomo): *(En cada visita desde los 6 meses hasta los 6 años)*	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**
1. ¿Su niño/a ha vivido o se ha quedado en alguna casa o apartamento que se haya construido antes del 1978? (incluyendo el centro de cuido, hogar prescolar, casa de la niñera o algún pariente)	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿Hay alguien en su casa que haya sido tratado por envenenamiento con Plomo?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. ¿Ha habido renovaciones recientes o se ha pelado la pintura en alguna casa que su hijo/a visite a menudo?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Su niño/a lame, come o mastica cosas que no sean comida? (pedacitos de pintura, tierra, rejas, barrotes, columnas, muebles, juguetes viejos, etc.)	S / N	S / N	S / N	S / N	S / N	S / N	S / N
5. ¿Hay algún familiar que esté trabajando en una ocupación o pasatiempo donde sea posible que se haya expuesto al plomo? (mecánico de autos, ceramista, pintor comercial, etc.)	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Evaluación sobre riesgo de Tuberculosis: *(Empezando en un año y anualmente a partir de esa fecha)*	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**	**fecha**
1. ¿ Ha sido su hijo/hija expuesto a una persona con un caso de Tuberculosis **o** ha alguien con una prueba cutanea de tuberculina positiva?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿ Fue su hijo/hija nacido, o algun mienbro en su hogar, en un pais de alto-riesgo (paises que no sean los Estados Unidos, Canada, Australia, Nueva Zelanda, o paises de Europa occidentales o del norte)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. ¿ Ha viajado su hijo/hija (tuvo contacto con la poblacion residente) de un pais de alto-riesgo por mas de una semana?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Tiene su niño/a contacto diario con adultos que esten en alto riesgo de tener o contraer tuberculosis (ejemplo: personas con la infección del VIH, vagabundas (homeless), encarceladas, y/o que usen drogas)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
5. ¿Tiene su niño la infección del VIH (HIV)? (una respuesta afirmativa a cualquier pregunta indica un posible riesgo)	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Detección de anemia *(A partir de 11 años de edad y anualmente en lo sucesivo)*							
1. ¿Incluye su dieta alimentos abundantes en hierro como carne, huevos, cereales fortificados con hierro o frijoles?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿Ha sido diagnosticado alguna vez con anemia por deficiencia de hierro?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. (sólo mujeres) ¿Tiene sangrado menstrual excesivo u otras pérdidas de sangre?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿ (sólo mujeres) Dura su periodo menstrual más de 5 días?	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Nombre del Paciente:_____Fecha de Nacimiento:_____

Programa para Niños Saludables de Maryland (Maryland Healthy Kids Program)
Cuestionario de Detección Temprana

Evaluación de Riesgo de Enfermedad del Corazón/ Enfermedad del Colesterol: *(Desde los 2 años hasta los 20 años)*	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____
1. ¿Hay un historial familiar de padres/abuelos menores de 55 años con ataques al corazón, cirugías, angina o muerte repentina a causa de un ataque al corazón?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿El padre o la madre del niño han sido diagnosticados con colesterol alto (240 mg/dL o más alto)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
(Una respuesta afirmativa a cualquiera de estas dos preguntas indica un riesgo definitivo.)							
3. ¿Está su niño/adolescente sobrepeso?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Hay un historial personal de:							
Fumar?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
Falta de actividad física/ejercicios?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
Presión Alta?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
Colesterol Alto?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
Diabetes?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
(Una respuesta afirmativa en las preguntas 3 y 4 indica riesgo)							

Evaluación de riesgo de ETS/VIH: *(Desde los 11 años hasta los 20)*	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____	**fecha** _____
1. ¿Ha recibido una transfusión de sangre o tiene hemofilia?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿Han abusado de usted física o sexualmente?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. ¿Ha sido diagnosticado con alguna enfermedad de transmisión sexual (gonorrea, sífilis, verrugas venéreas, clamidia, herpes, virus de papiloma humano (HPV))?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Tiene su pareja sexual, tiene usted o tuvo su madre durante el embarazo algún historial de uso de drogas intravenosas?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
5. Si está sexualmente activo/a ¿Ha tenido sexo sin protección con alguien del sexo opuesto/mismo sexo (circule la respuesta apropiada)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
6. Si está sexualmente activo/a ¿Ha tenido más de una pareja?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
7. ¿Tiene algún tatuaje o perforaciones en las orejas, ombligo, etc. incluyendo cualquiera hecho por sus amigos?	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Nombre del Paciente:_____Fecha de Nacimiento:_____

SEEK™
Safe Environment for Every Kid

Parent Questionnaire (PQ)

Dear Parent or Caregiver: Being a parent is not always easy. We want to help families have a safe environment for kids. So, we're asking everyone these questions. They are about problems that affect many families. If there's a problem, we'll try to help.

Please answer the questions about your child being seen today for a checkup. If there's more than one child, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to.

Today's Date: ___/___/____ Child's Name: _____

Child's Date of Birth: __/___/____

PLEASE CHECK

□ Yes	□ No	Do you need the phone number for Poison Control?
□ Yes	□ No	Do you need a smoke detector for your home?
□ Yes	□ No	Does anyone smoke tobacco at home?
□ Yes	□ No	In the last year, did you worry that your food would run out before you got money or Food Stamps to buy more?
□ Yes	□ No	In the last year, did the food you bought just not last and you didn't have money to get more?
□ Yes	□ No	Do you often feel your child is difficult to take care of?
□ Yes	□ No	Do you sometimes find you need to hit/spank your child?
□ Yes	□ No	Do you wish you had more help with your child?
□ Yes	□ No	Do you often feel under extreme stress?
□ Yes	□ No	In the past month, have you often felt down, depressed, or hopeless?
□ Yes	□ No	In the past month, have you felt very little interest or pleasure in things you used to enjoy?
□ Yes	□ No	In the past year, have you been afraid of your partner?
□ Yes	□ No	In the past year, have you had a problem with drugs or alcohol?
□ Yes	□ No	In the past year, have you felt the need to cut back on drinking or drug use?
□ Yes	□ No	Are there any other problems you'd like help with today?

Please give this form to the doctor or nurse you're seeing today. Thank you!

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Cuestionario para padres

Estimada/o Madre, Padre o Tutor: Ser padre no siempre es fácil. Queremos ayudarla/o a crear un ambiente seguro para los niños. Por eso estamos haciendo preguntas sobre problemas que afectan a muchas familias. Si hay un problema, intentaremos ayudar.

Por favor, conteste las siguientes preguntas acerca de su hijo/a que hoy nos visita para su consulta médica. Si tiene más de un niño, responda "sí" cuando se aplique a alguno de ellos.

Fecha de hoy ___/___/___ Nombre del niño/a: _____
Fecha de nacimiento del niño/a: ___/___/___

1. ¿Necesita el número telefónico de la Central de Envenenamiento (*Poison Control*)?
   - ◯ Sí
   - ◯ No
2. ¿Necesita un detector de humo en su hogar?
   - ◯ Sí
   - ◯ No
3. ¿Alguien fuma tabaco en su hogar?
   - ◯ Sí
   - ◯ No
4. Durante el año pasado, ¿alguna vez se preocupó porque se le iba a acabar la comida antes de recibir dinero o los bonos de alimentos (*food stamps*)?
   - ◯ Sí
   - ◯ No
5. Durante el año pasado, ¿alguna vez se le acabó la comida que había comprado y no tuvo dinero para conseguir más?
   - ◯ Sí
   - ◯ No
6. ¿Siente a menudo que su niño/a es difícil de cuidar?
   - ◯ Sí
   - ◯ No
7. ¿Siente a veces que es necesario golpear a su niño/a o darle una cachetada?
   - ◯ Sí
   - ◯ No
8. ¿Desearía tener más ayuda para criar a su niño/a?
   - ◯ Sí
   - ◯ No
9. ¿Siente a menudo que se encuentra bajo un estrés extremo?
   - ◯ Sí
   - ◯ No

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10. Durante el mes pasado, ¿se ha sentido a menudo abatido, deprimido o desesperado?
    - ◯ Sí
    - ◯ No
11. Durante el mes pasado, ¿ha sentido que ha perdido el interés o el gusto en cosas que solía disfrutar?
    - ◯ Sí
    - ◯ No
12. Durante el año pasado, ¿ha tenido miedo de su pareja?
    - ◯ Sí
    - ◯ No
13. Durante el año pasado, ¿ha tenido problemas con las drogas o el alcohol?
    - ◯ Sí
    - ◯ No
14. Durante el año pasado, ¿ha sentido que debería disminuir el consumo de alcohol o drogas?
    - ◯ Sí
    - ◯ No
15. ¿Tiene algún otro problema para el que quisiera ayuda hoy?
    - ◯ Sí
    - ◯ No

Por favor entregue este formulario a su médico o enfermera. ¡Gracias!

Victimization Scale
English Version

Think about what happened DURING THE LAST 7 DAYS, when you answer these questions.

	During the last 7 days:	0 times	1 time	2 times	3 times	4 times	5 times	6 or more times
1.	A student teased me to make me angry.	0	1	2	3	4	5	6+
2.	A student beat me up.	0	1	2	3	4	5	6+
3.	A student said things about me to make other students laugh (made fun of me).	0	1	2	3	4	5	6+
4.	Other students encouraged me to fight.	0	1	2	3	4	5	6+
5.	A student pushed or shoved me.	0	1	2	3	4	5	6+
6.	A student asked me to fight.	0	1	2	3	4	5	6+
7.	A student slapped or kicked me.	0	1	2	3	4	5	6+
8.	A student called me (or my family) bad names.	0	1	2	3	4	5	6+
9.	A student threatened to hurt or to hit me.	0	1	2	3	4	5	6+
10.	A student tried to hurt my feelings.	0	1	2	3	4	5	6+

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Victimization Scale for Middle School Children-Instructions

DESCRIPTION	The Victimization Scale for middle school children was designed to measure frequency of self-reported victimization during the week prior to the survey. The scale was developed based on the aggression scale for middle school students (Orpinas & Frankowski, 2001). The scale is also described in CDC's widely-utilized compendium of measures of violence-related attitudes and behaviors (CDC, 1998, 2005; http://www.cdc.gov/ncipc/pub-res/measure.htm).
RESPONSE FORMAT	0 = 0 times 1 = 1 time 2 = 2 times 3 = 3 times 4 = 4 times 5 = 5 times 6 = 6+ times
INTENDED RESPONDENTS	Middle school students, grades 6-8, and upper elementary students (grades 3-5).
SCORING AND DIRECTION	The scores are additive, and the scale ranges from 0 to 60 points. High values indicate higher frequency of being the victim of aggressive acts.
RELIABILITY	In a sample of 9115 middle school students from Texas, the internal consistency of the scores, as measured by Cronbach's alpha, was .85 (Boys = .86; girls = .84).
MISSING VALUES	Scale scores were only calculated if at least eight items were nonmissing.

Escala de Victimización para Estudiantes

Items Spanish Version

Contesta las siguientes preguntas pensando en lo que realmente te pasó a ti en los últimos 7 días. Para cada pregunta, marca cuántas veces otro estudiante te hizo algo en los últimos 7 días.

	En los últimos 7 días...	**0 veces**	**1 vez**	**2 veces**	**3 veces**	**4 veces**	**5 veces**	**6 veces o más**
1.	Un estudiante me hizo bromas (me molestó) para que yo me enojara.	0	1	2	3	4	5	6+
2.	Un estudiante me dio una paliza (golpiza).	0	1	2	3	4	5	6+
3.	Un estudiante dijo cosas sobre mí para hacer reír a otros estudiantes.	0	1	2	3	4	5	6+
4.	Otros estudiantes me alentaron (estimularon, aconsejaron) a pelear.	0	1	2	3	4	5	6+
5.	Un estudiante me empujó.	0	1	2	3	4	5	6+
6.	Un estudiante me invitó a pelear.	0	1	2	3	4	5	6+
7.	Un estudiante me dio una bofetada (cachetada, palmada) o patada.	0	1	2	3	4	5	6+
8.	Un estudiante me insultó a mí o a mi familia.	0	1	2	3	4	5	6+
9.	Un estudiante me amenazó con herirme o golpearme	0	1	2	3	4	5	6+
10.	Un estudiante trató de herir mis sentimientos.	0	1	2	3	4	5	6+

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Immunization Forms and Resources

Maryland Immunization Certification Form *Updated 2014*

Maryland Recommended Childhood and Adolescent Immunization Schedule
(Includes Child/Adolescent "Catch up" Schedule) *Updated 2016*

Maryland Suggested Combination Vaccines Schedule *Updated 2011*

Parental Delegation Form for Minors

VFC Vaccine Inventory Form *Updated 2015*

VFC Log of Children Receiving VFC Vaccines *Updated 2013*

VFC Patient Eligibility Screening Record *Updated 2015*

VFC Program Contact Center *Updated 2016*

VFC Vaccine Administration Record *Updated 2015*

VFC Vaccine Return and Wastage Form *Updated 2015*

VFC Vaccine Storage Temperature Log *Updated 2011*

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease
1									1				Mo/Yr
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Maryland Department of Health and Mental Hygiene

2016 Recommended Childhood Immunization Schedule

Vaccine ▼ / Age ►	Birth	2 months	4 months	6 months	12 months	15 months	18 months	2-3 years	4-6 years
Hepatitis B[1]	**Hep B**	**Hep B**		**Hep B**					
Rotavirus[2]		**RV**	**RV**	**RV**					
Diphtheria, tetanus, & acellular pertussis[3]		**DTaP**	**DTaP**	**DTaP**		**DTaP**			**DTaP**
Haemophilus Influenzae type b[4]		**Hib**	**Hib**	**Hib**		**Hib**			**Hib**
Pneumococcal[5]		**PCV13**	**PCV13**	**PCV13**	**PCV13**			**PPSV23**	
Inactivated Poliovirus[6]		**IPV**	**IPV**	**IPV**					**IPV**
Influenza[7]				**INFLUENZA (YEARLY)**					
Measles, Mumps, Rubella[8]					**MMR**				**MMR**
Varicella[9]					**Var**				**Var**
Hepatitis A[10]					**HepA**		**HepA**	**HepA**	
Meningococcal[11]		**Meningococcal**							

Please see reverse side for footnotes

Certain High-Risk Groups & Catch-Up Vaccination

Certain High-Risk Groups

This schedule includes recommendations in effect as of January 01, 2016. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967)

Approved by MedChi - The Maryland State Medical Society

www.dhmh.maryland.gov **Center for Immunization** **dhmh.IZinfo@maryland.gov**

Maryland Department of Health and Mental Hygiene

2016 Recommended Adolescent Immunization Schedule

Vaccine ▼ / Age ►	7 - 10 Years	11-12 Years	13 –18 Years
Tetanus, Diphtheria, Pertussis[12]	Tdap (if indicated)	Tdap	Tdap
Human Papillomavirus[13]	HPV	HPV (3 Doses)	HPV (3 Doses)
Meningococcal[11]	MCV4	MCV4	MCV4 Booster At Age 16
Influenza[7]	Influenza (Yearly)		
Hepatitis B[1]	Complete Hep B Series		
Inactivated Polio[6]	Complete Inactivated Polio		
Measles, Mumps, Rubella[8]	Complete MMR Series		
Varicella[9]	Complete Varicella Series		
Hepatitis A[10]	Complete Hep A Series		
Meningococcal B[11]	Meningococcal B		
Pneumococcal[5]	Pneumococcal		
Haemophilus Influenzae type b[4]	Haemophilus Influenzae type b		

Please see reverse side for footnotes

Do not restart any series when there is proof of prior vaccination, just complete series by administering missing doses.

Recommended ages for all Adolescents | **Catch-Up Vaccination** | **Certain High-Risk Groups & Catch-Up Vaccination** | **Certain High-Risk Groups**

This schedule includes recommendations in effect as of January 01, 2016. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

Approved by MedChi—The Maryland State Medical Society

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FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks *and* at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks *and* age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months (wait until at least 12 months old); OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday (wait until at least 12 months old). No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6]	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[12]	7 years[12]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[13]	9 years	Routine dosing intervals are recommended.[13]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	4 weeks[6]	6 months[6]	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see *MMWR, General Recommendations on Immunization and Reports* / Vol. 60 / No. 2; Table 1. *Recommended and minimum ages and intervals between vaccine doses* available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.
- For vaccination of persons with primary and secondary immunodeficiencies, see Table 13, *"Vaccination of persons with primary and secondary immunodeficiencies,"* in *General Recommendations on Immunization* (ACIP), available at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.; and American Academy of Pediatrics. "Immunization in Special Clinical Circumstances," in Kimberlin DW, Brady MT, Jackson MA, Long SS eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the **first** dose. The final (third or fourth) dose in the HepB vaccine series should be administered **no earlier than age 24 weeks**.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])

Routine vaccination:

Administer a series of RV vaccine to all infants as follows:

1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:

- The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix, Quadracel]: 4 years)

Routine vaccination:

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (cont'd)

Catch-up vaccination:

- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up guidance, see Figure 2.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])

Routine vaccination:

- Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
- The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hiberix vaccine. Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.
- For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Catch-up vaccination:

- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If both doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered before the first birthday, the third (and final) dose should be administered at age 12 through 59 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
- For unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination of persons with high-risk conditions:

- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine (cont'd)**
   - Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.

     ** Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.*

5. **Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)**

   Routine vaccination with PCV13:
   - Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.
   - For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

   Catch-up vaccination with PCV13:
   - Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For other catch-up guidance, see Figure 2.

   Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
   - All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
   - For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
     1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
     4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
     5. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
   - For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
     1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
     2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
     3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
   - For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
   - A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)**

   Routine vaccination:
   - Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

   Catch-up vaccination:
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks) (cont'd)**
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age. If only OPV were administered, and all doses were given prior to 4 years of age, one dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
   - For other catch-up guidance, see Figure 2.

7. **Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])**

   Routine vaccination:
   - Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) persons who have experienced severe allergic reactions to LAIV, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunosuppressed persons; 6) children 2 through 4 years of age with asthma or who had wheezing in the past 12 months; or 7) persons who have taken influenza antiviral medications in the previous 48 hours. For all other contraindications and precautions to use of LAIV, see *MMWR* August 7, 2015 / 64(30):818-25 available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.

   For children aged 6 months through 8 years:
   - For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations, *MMWR* August 7, 2015 / 64(30):818-25, available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.
   - For the 2016-17 season, follow dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

   For persons aged 9 years and older:
   - Administer 1 dose.

8. **Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)**

   Routine vaccination:
   - Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
   - Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

   Catch-up vaccination:
   - Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

9. **Varicella (VAR) vaccine. (Minimum age: 12 months)**

   Routine vaccination:
   - Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

   Catch-up vaccination:
   - Ensure that all persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007 / 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

10. **Hepatitis A (HepA) vaccine. (Minimum age: 12 months)**

    Routine vaccination:
    - Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
    - Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    - For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

    Catch-up vaccination:
    - The minimum interval between the 2 doses is 6 months.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

10. Hepatitis A (HepA) vaccine (cont'd)

Special populations:

- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-FHbp [Trumenba])

Routine vaccination:

- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:

- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Clinical discretion:

- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:

Children with anatomic or functional asplenia (including sickle cell disease):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination at 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. Menactra
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properidin, factor D, factor H, or taking eculizumab (Soliris®):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

11. Meningococcal vaccines (cont'd)

3. Menactra
   - *Children 9 through 23 months:* Administer 2 primary doses at least 12 weeks apart.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj

- administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during a community outbreak attributable to a vaccine serogroup

- administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo, Bexsero or Trumenba.

For booster doses among persons with high-risk conditions, refer to *MMWR* 2013 / 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

For other catch-up recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see *MMWR* March 22, 2013 / 62(RR02);1-22, and *MMWR* October 23, 2015 / 64(41); 1171-1176 available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and http://www.cdc.gov/mmwr/pdf/wk/mm6441.pdf.

12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:

- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine vaccination:

- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

Catch-up vaccination:

- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

Maryland Suggested Immunization Schedule Using Combination Vaccines

	BIRTH	2 MONTHS	4 MONTHS	6 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	4-6 YEARS
Schedule Using **PEDIARIX & KINRIX**	HepB	PEDIARIX DTaP, IPV, HepB + PCV13, Rotavirus[2], HIB	PEDIARIX DTaP, IPV, HepB + PCV13, Rotavirus[2], HIB	PEDIARIX DTaP, IPV, HepB[1] + PCV13, Rotavirus[2], HIB[3]	HepA, MMR, Varicella, PCV13	DTaP, HIB	HepA	KINRIX DTaP, IPV + MMR, Varicella
				EVERY FALL: FLU VACCINE Children age 6 months through 18				
Schedule Using **PENTACEL & KINRIX**	HepB	PENTACEL DTaP, IPV, Hib + PCV13, Rotavirus[2], HepB	PENTACEL DTaP, IPV, Hib + PCV13, Rotavirus[2]	PENTACEL DTaP, IPV, Hib + PCV13, Rotavirus[2], HepB	HepA, MMR, Varicella, PCV13	PENTACEL DTaP, IPV[4], Hib	HepA	KINRIX DTaP, IPV + MMR, Varicella
				EVERY FALL: FLU VACCINE Children age 6 months through 18				

The Advisory Committee on Immunization Practices (ACIP) states:
The use of a combination vaccine is preferred over separate injections of its equivalent component vaccines.

This is a suggested schedule for Maryland VFC providers utilizing combination vaccines.

1. Use of Pediarix (DTaP-HepB-IPV) after single antigen HepB vaccine administered at birth will result in a 4-dose HepB vaccine series; this is considered acceptable by ACIP.
2. The rotavirus vaccines differ in number of doses and timing. Check the package insert.
3. This six month Hib dose is not indicated if Pedvax HIB and/or Comvax are used exclusively for the 2 and 4 month infant doses.
4. Pentacel (DTaP-IPV/Hib) can be used to complete the series of Hib vaccination, even if the child already received all the necessary doses of DTaP and IPV.

Additional guidance from the ACIP on the Use of Combination Vaccines for Childhood Immunization.

(CDC MMWR 5/14/99 Combination Vaccines for Childhood Immunization)

- The use of combination vaccines is a practical way to overcome the constraints of multiple injections, especially for starting the immunization series for children behind schedule. The use of combination vaccines might improve timely vaccination coverage. Some immunization providers and parents object to administering more than two or three injectable vaccines during a single visit because of a child's fear of needles and pain and because of unsubstantiated concerns regarding safety.
- Advantages of combination vaccines include a) reducing the cost of stocking and administering separate vaccines, b) reducing the cost for extra health-care visits, and c) facilitating the addition of new vaccines into immunization programs. The price of a new combination vaccine can sometimes exceed the total price of separate vaccines for the same diseases. However, the combination vaccine might represent a better economic value if one considers the direct and indirect costs of extra injections, delayed or missed vaccinations, and additional handling and storage.
- Using combination vaccines containing some antigens not indicated at the time of administration to a patient might be justified when a) products that contain only the needed antigens are not readily available or would result in extra injections and b) potential benefits to the child outweigh the risk of adverse events associated with the extra antigen(s). An extra dose of many live-virus vaccines and Hib or Hepatitis B vaccines has not been found to be harmful. However, the risk of adverse reactions might increase when extra doses are administered earlier than the recommended interval for certain vaccines (e.g., tetanus toxoid vaccines and pneumococcal polysaccharide vaccine).
- Patients commonly receive extra doses of vaccines or vaccine antigens for diseases to which they are immune. For example, some children receiving recommended second or third doses of many vaccines in the routine immunization series will already have immunologic protection from previous dose(s). Because serologic testing for markers of immunity is usually impractical and costly, multiple doses for all children are justified for both clinical and public health reasons to decrease the number of susceptible persons, which ensures high overall rates of protection in the population.
- ACIP, AAP, and AAFP recommend that combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. An immunization provider might not have vaccines available that contain only those antigens indicated by a child's immunization history. Alternatively, the indicated vaccines might be available, but the provider nevertheless might prefer to use a combination vaccine to reduce the required number of injections. In such cases, the benefits and risks of administering the combination vaccine with an unneeded antigen should be compared.

Source: CDC, January 28, 2011, Morbidity and Mortality Weekly Report (MMWR), General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices (ACIP), Vol. 60/ No. 2.

Parental Delegation Form
Authorizing the Immunization of a Minor

I, _____, am the

- ☐ Natural or adoptive
- ☐ Guardian of
- ☐ Person who, under court order, is authorized to give consent for

the minor, _____.
print name of minor

I, hereby, delegate _____
print name of person to whom authority is delegated

to give consent to the immunization of the above named minor. The relationship of this person to the minor is:

- ☐ A grandparent
- ☐ An adult brother or sister
- ☐ An adult aunt or uncle
- ☐ A stepparent
- ☐ Another adult who has care and control of the above named minor

_____	_____
Signature of Parent or Guardian	Witness
_____	_____
Date	Date

Confirmation Form for Person Other than the Parent Consenting to the Immunization of a Minor

I, _____, am
print name

☐ A grandparent

☐ An adult brother or sister

☐ An adult aunt or uncle

☐ A stepparent

☐ Another adult who has care and control

☐ An adult who has care and control of the minor named below under an order of a court or by commitment by a court to the care of an agency of the state or county and reasonably believe the minor needs immunization

of _____, a minor whose (*check one)* ☐ natural or adoptive parent,
print name of minor
☐ guardian, ☐ person who, under court order, is authorized to give consent for the minor is

_____ and for whom I am giving consent for immunization.
*print name of parent**
.
The following describes the situation of alternate consent:

☐ The parent* has verbally delegated the authority to me to consent for immunization of the above-named minor and I have sufficient information about the minor and the minor's family to enable me to consent.

☐ The parent* is not reasonably available because:

- ☐ the location of the person is unknown.
- ☐ I have made a reasonable effort within the past 90 days to locate and communicate with the parent* for the purpose of obtaining consent and that attempt has failed.
- ☐ I have contacted the parent* and requested that the parent* consent to the immunization and no action has been taken on the request but I have not been expressly denied the authority to consent to the immunization of the above-named minor.

_____	_____
Signature of Person Giving Consent	Witness
_____	_____
Date	Date

*"Parent" is defined as the natural or adoptive parent, the guardian, or a person who, under court order, is authorized to give consent for the minor.

MARYLAND VFC PROGRAM VACCINE INVENTORY FORM

Fax Pages 1 & 2 To: 410-333-5893

VFC PIN #: (REQUIRED)	Today's Date: (REQUIRED) / /	Phone: (REQUIRED)	Fax:
Name of Physician's Office, Practice, Clinic, Etc.: (REQUIRED)		Contact Person: (REQUIRED)	
Special Delivery Instructions:		Contact Email:	

Vaccine Brand Name (alphabetical order)	NDC #	VFC Vaccine Lot # (REQUIRED)	# of VFC Doses on Hand	Expiration Date (REQUIRED)	*ADDITIONAL VFC Vaccine Lot #*	*# of VFC Doses on Hand*	*ADDITIONAL Expiration Date*
ActHIB *Vials* (Hib)	49281-0545-05						
Adacel *Syringes* (Tdap)	49281-0400-15						
Adacel *Vials* (Tdap)	49281-0400-10						
Boostrix *Syringes* (Tdap)	58160-0842-52						
Boostrix *Vials* (Tdap)	58160-0842-11						
Daptacel *Vials* (DTaP)	49281-0286-10						
Engerix B *Syringes* (Hepatitis B)	58160-0820-52						
Engerix B *Vials* (Hepatitis B)	58160-0820-11						
Gardasil 4 *Vials* (HPV)	00006-4045-41						
Gardasil 9 *Vials* (HPV)	00006-4119-03						
Havrix *Syringes* (Hepatitis A)	58160-0825-52						
Havrix *Vials* (Hepatitis A)	58160-0825-11						
Infanrix *Syringes* (DTaP)	58160-0810-52						
Infanrix *Vials* (DTaP)	58160-0810-11						
IPOL *Vials* (IPV)	49281-0860-10						
Kinrix *Syringes* (DTaP/IPV)	58160-0812-52						
Kinrix *Vials* (DTaP/IPV)	58160-0812-11						

MARYLAND VFC PROGRAM VACCINE INVENTORY FORM Fax Pages 1 & 2 To: 410-333-5893

VFC PIN #: (REQUIRED)	Name of Physician's Office, Practice, Clinic, Etc.: (REQUIRED)	Today's Date: (REQUIRED)
		/ /

Vaccine Brand Name	NDC #	VFC Vaccine Lot # (REQUIRED)	# of VFC Doses on Hand	Expiration Date (REQUIRED)	*ADDITIONAL VFC Vaccine Lot #*	*# of VFC Doses on Hand*	*ADDITIONAL Expiration Date*
Menactra *Vials* (MCV4)	49281-0589-05						
Menveo *Vials* (MCV4)	46028-0208-01						
MMR-II *Vials* (MMR)	00006-4681-00						
Pediarix *Syringes* (DTAP/Hep B/IPV)	58160-0811-52						
PedvaxHIB *Vials* (Hib)	00006-4897-00						
Pentacel *Vials* (DTaP/IPV/Hib)	49281-0510-05						
Pneumo. Conju. *Syringe* (PCV13)	00005-1971-02						
ProQuad *Vials* (MMRV)	00006-4999-00						
Recombivax *Syringes* (Hepatitis B)	00006-4981-09						
Recombivax *Vials* (Hepatitis B)	00006-4981-00						
Rotarix *Vials* (Rotavirus)	58160-0854-52						
RotaTeq *Vials* (Rotavirus)	00006-4047-41						
Vaqta *Syringes* (Hepatitis A)	00006-4831-09						
Vaqta *Vials* (Hepatitis A)	00006-4831-41						
Varivax *Vials* (Varicella)	00006-4827-00						

Helpful tips for completing your VFC Inventory Form:

- **MenB, Td, DT, PPV23, & Hiberix available by written request to 410-333-5893 (fax)**
- **Write "0" next to a vaccine if you do not have any in stock**
- **Include ALL lot numbers, expiration dates, and respective quantities**
- **If you have additional lot numbers, make copies of this form**
- **Do not report expired vaccine on this form; list it on a Vaccine Return Form**
- **Write neatly and clearly**

VFC Contact Center

(410) 274-6240: Baltimore, Baltimore City, Harford, Howard
(410) 299-5647: Frederick, Montgomery, Prince George's
(410) 404-4128: All other counties

Incomplete inventories will NOT be processed.

Log of Children Receiving Vaccines for Children (VFC) Vaccines

(1.) Indicate the child's VFC eligibility: List Medical Assistance Number if applicable. If Child is uninsured, write in "Uninsured". If Child is under-insured (insurer does not pay for cost of vaccines), write in the insurer and policy information. (2.) Check (✓) each vaccine administered. (3.) Total the number of doses.

VFC PIN:
PRACTICE:
DATE RANGE: / / to / /

	CHILD'S NAME	DOB	VFC ELIGIBILITY	DTaP	Hep A	Hep B	Hib	HPV	Influenza	Kinrix	MCV 4	MMR	PCV 13	Pediarix	Pentacel	Polio	Proquad	Rotavirus	Tdap	Varicella
1.		/ /																		
2.		/ /																		
3.		/ /																		
4.		/ /																		
5.		/ /																		
6.		/ /																		
7.		/ /																		
8.		/ /																		
9.		/ /																		
10.		/ /																		
11.		/ /																		
12.		/ /																		
13.		/ /																		
14.		/ /																		
VACCINE DOSE TOTALS ➤																				

Maryland Vaccines for Children Program

Fax to: 410-333-5893

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Baltimore, Maryland 21201

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

***Providers must screen and properly document eligibility status at each immunization visit.**

VFC #: _____

Health Care Provider: _____

Patient: _____ DOB: _____

Date	VFC Eligibility (birth through 18 years of age)					Staff's initials
	Medicaid	Uninsured	Native American/ Alaskan Native	Underinsured (refer to LHD/FQHC)	Not VFC Eligible	

Patient: _____ DOB: _____

Date	VFC Eligibility (birth through 18 years of age)					Staff's initials
	Medicaid	Uninsured	Native American/ Alaskan Native	Underinsured (refer to LHD/FQHC)	Not VFC Eligible	

Center for Immunization

Home
PHPA

Lists

HPTIMELINE

Hot Topics

Ebola
Influenza (Flu)
Vaccines for Children (VFC)
Back to School
Flu Information

Maryland Immunization Registry (ImmuNet)

ImmuNet Home
Login to ImmuNet
ImmuNet Providers
Pharmacists
Schools
FAQ
Contact Us

VFC Contact Center

The Maryland VFC Program is pleased to introduce the VFC Contact Center. The VFC Contact Center will serve as the new central point for addressing your VFC-related questions. The new VFC Contact Center will provide a full range of support for VFC Providers including answering questions related to VFC vaccine supply, vaccine delivery, vaccine allocations and other related issues.

VFC Providers can reach the VFC Contact Center, by telephone, email or fax. Hours of operation will be 8:00 a.m. to 5:00 p.m., Monday through Friday except for holidays.

VFC Contact Center
201 W.Preston Street
Suite 318
Baltimore, MD 21201
Email to: Center for Immunization
410-333-5893 (fax)

To improve customer service and ensure timely responses VFC Providers in each jurisdiction have been assigned a phone number to reach the VFC Contact Center. Please review the list below to find your assigned VFC Contact Center phone number.

410-404-4128	410-299-5647	410-274-6240
Allegany	Frederick	Baltimore City
Anne Arundel	Montgomery	Baltimore County
Calvert	Prince George's	Harford
Caroline		Howard
Carroll		
Cecil		
Charles		
Dorchester		
Garrett		
Kent		

Quick Reference

- Reportable Diseases
- Fact Sheets
- Guidelines

Hot Topics

- Get a Flu Shot

Contact Us

Center for Immunization Email:
DHMH.ZInfo@maryland.gov

Queen Anne's
St.Mary's
Somerset
Talbot
Washington
Wicomico
Worcester

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201 W. Preston Street, Baltimore, MD 21201-2399

(410) 767-6500 or 1-877-463-3464

Vaccine Administration Record

Patient Name: _____

Date of Birth: ___/___/___

Parent/Guardian Signature: _____
(Optional)

Provider/Clinic Name & Address:

VACCINE* (Please Circle Appropriate Vaccine)	Date Administered	Vaccine Manufacturer	Vaccine Lot Number	Name and Title of Vaccine Administrator	Date Vaccine Information Statements Given	Publication Date of Vaccine Information Statements
DTaP 1 or DT 1						05/17/07
DTaP 2 or DT 2						05/17/07
DTaP 3 or DT 3						05/17/07
DTaP 4 or DT 4						05/17/07
DTaP 5 or DT 5						05/17/07
IPV 1						11/08/11
IPV 2						11/08/11
IPV 3						11/08/11
IPV 4						11/08/11
Hib 1						04/02/15
Hib 2						04/02/15
Hib 3						04/02/15
Hib 4						04/02/15
PCV 1						02/27/13
PCV 2						02/27/13
PCV 3						02/27/13
PCV 4						02/27/13
MMR 1						04/20/12
MMR 2						04/20/12
Varicella 1						03/13/08
Varicella 2						03/13/08
History of Varicella Disease Date (month/year):						
Hepatitis B 1						02/02/12
Hepatitis B 2						02/02/12
Hepatitis B 3						02/02/12
Influenza 1						Annual
Influenza 2						Annual
Tdap						02/24/15
Td						02/24/15
MCV						10/14/11
MCV						10/14/11
Meningococcal B						08/14/15
Hepatitis A 1						10/25/11
Hepatitis A 2						10/25/11
Rotavirus 1						04/15/15
Rotavirus 2						04/15/15
Rotavirus 3						04/15/15
HPV9 1						04/15/15
HPV9 2						04/15/15
HPV9 3						04/15/15

*** -** When combination vaccines are given, enter the vaccine information in each separate vaccine row.

Please Note: Vaccine Information Statements dates are subject to change, please check the CDC website for the most current VIS.

MARYLAND VACCINES FOR CHILDREN PROGRAM

Vaccine Return and Wastage Form

VFC PIN: _____ **PRACTICE NAME:** _____

PHONE: _____ **FAX:** _____

COMPLETED BY: _____ **DATE:** _____

EMAIL: _____

Instructions for Completion:

1. **Immediately remove any wasted or expired/spoiled vaccine from the refrigerator or freezer**.
2. Complete this form and fax a copy to the VFC Program at 410-333-5893.
3. Upon receipt, VFC will email a confirmation and the Vaccine Transaction Receipt to be enclosed in the package with the vaccine being returned. DO NOT attempt to return wasted vaccine (opened and unused multi-dose vials, broken vials/syringe, etc). Wasted vaccine should be disposed of according to facility protocol.
4. Upon receipt of the shipping label(s) from McKesson, attach label to the container and give to UPS. Clearly label the outside of the shipping container "Non-viable Vaccine enclosed".

EXPIRED / SPOILED VACCINE ONLY: Vaccine in which the date listed on the vaccine container has elapsed / Vaccine that is no longer viable due to lack of proper storage

Vaccine	Manufacturer	NDC number	Number of Doses	Expiration Date
Reason for return:				

WASTAGE ONLY: Broken vial/syringe; Vaccine drawn up into syringe but not administered; Lost or unaccounted for vaccine; Non-vaccine product (e.g., diluent); Partially used multi-dose vial

Vaccine	Manufacturer	NDC number	Number of Doses	Expiration Date
Reason for wastage:				

By signing below, you agree that you have disposed of the wasted vaccine listed above according to your facility's protocol.

_____ _____

Name (Signed) **Name (Printed)** **Date**

If you have any questions, please call the VFC Contact Center for your jurisdiction.

F° Check Both Temperatures Twice A Day

Month: _____

Days 1–15 (16-31 continued on other side)

Refrigerator

	Staff Initials																													
	Day of Month	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15	
	Time																														
		am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm
Too high*	≥ 49°F																														
	48°F																														
	47°F																														
	46°F																														
	45°F																														
	44°F																														
	43°F																														
	42°F																														
	41°F																														
Aim for	**40°F**																														
	39°F																														
	38°F																														
	37°F																														
	36°F																														
	35°F																														
Too low*	34°F																														
	33°F																														
	≤ 32°F																														

Take immediate action* if temperature is in the shaded area.

If temperature is above 49° F, write in the current temperature.

If temperature is below 32° F, write in the current temperature.

Take immediate action* if temperature is in the shaded area.

Freezer

Too high*	≥ 8°F																													
	7°F																													
	6°F																													
	5°F																													
	4°F																													
	≤ 3°F																													

Take immediate action* if temperature is in the shaded area.

If temperature is above 8° F, write in the current temperature.

Check both temperatures twice a day, each working day of the month. Place an "X" in the boxes that show the temperatures you read in the morning and afternoon; enter your initials and the time in the boxes at the top of the day's column. If your entry is in a shaded area, take immediate action! Use a new form each month and save in a file at month's end for one year.

***TAKE IMMEDIATE ACTION if the temperature is too high or too low:**

1. Store the vaccine under proper conditions as quickly as possible.
2. Call the VFC Contact Center

Vaccines for Children Program
Maryland Department of Health & Mental Hygiene
Izinfo@dhmh.state.md.us
www.ideha.dhmh.maryland.gov

Adapted by the MD Center for Immunization courtesy of the California Department of Health Services.

F° Check Both Temperatures Twice A Day

Month: _____

Days 16–31 (1-15 on other side)

Refrigerator

Staff Initials																														
Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Time																														
	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm
Too high* ≥ 49°F	Take immediate action* if temperature is in the shaded area.																													
48°F																														
47°F	If temperature is above 49° F, write in the current temperature.																													
46°F																														
45°F																														
44°F																														
43°F																														
42°F																														
41°F																														
Aim for **40°F**																														
39°F																														
38°F																														
37°F																														
36°F																														
35°F																														
Too low* 34°F	If temperature is below 32° F, write in the current temperature.																													
33°F																														
≤ 32°F	Take immediate action* if temperature is in the shaded area.																													

Freezer

Too high* ≥ 8°F	Take immediate action* if temperature is in the shaded area.																													
7°F																														
6°F	If temperature is above 8° F, write in the current temperature.																													
5°F																														
4°F																														
≤ 3°F																														

Check both temperatures twice a day, each working day of the month. Place an "X" in the boxes that show the temperatures you read in the morning and afternoon; enter your initials and the time in the boxes at the top of the day's column. If your entry is in a shaded area, take immediate action! Use a new form each month and save in a file at month's end for one year.

***TAKE IMMEDIATE ACTION if the temperature is too high or too low:**

1. Store the vaccine under proper conditions as quickly as possible.
2. Call the VFC Contact Center

Vaccines for Children Program
Maryland Department of Health & Mental Hygiene
Izinfo@dhmh.state.md.us
www.ideha.dhmh.maryland.gov

Adapted by the MD Center for Immunization courtesy of the California Department of Health Services.

Health Education Materials

Communicable Disease Fact Sheets *Updated 2011*

General Child Seat Use and Maryland Child Safety Seat Law *Updated 2010*

National Safe Kids Campaign Materials *Updated 2015*

Bicycle Safety *Updated 2013*

Fire Safety *Updated 2013*

Gun Safety *Updated 2013*

Poison Safety *Updated 2014*

Water Safety *Updated 2013*

My Plate *Updated 2015*

Order Forms for Educational Materials *Updated 2015*

CDC Tuberculosis Training Materials *Updated 2015*

Center for Immunization Health Education Materials Order Form *Updated 2014*

HIV/AIDS Prevention Materials Order Form *Updated 2013*

Kids in Safety Seats Educational Materials Order Form *Updated 2013*

Lead Poisoning Prevention Program Educational Materials Order Form *Updated 2008*

Maternal and Child Health Bureau Publication Order Form *Updated 2015*

Communicable Diseases Summary

A Guide for School Health Services Personnel, Child Care Providers and Youth Camps

Revised: November 2011

If you have questions about anything in this Summary, or other questions about communicable diseases:

Please call your local health department or the Maryland Department of Health and Mental Hygiene, Office of Infectious Disease Epidemiology and Outbreak Response (IDEOR) at 410-767-6700,

OR

Please check the DHMH website at <http://ideha.dhmh.maryland.gov/SIPOR/> for additional information.

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- Maryland Department of Health and Mental Hygiene (DHMH), Infectious Disease and Environmental Health Administration (IDEHA), Office of Infectious Disease Epidemiology and Outbreak Response (IDEOR)
- Maryland Department of Health and Mental Hygiene (DHMH), Family Health Administration (FHA), Center for Maternal and Child Health, School Health Services Program
- Maryland State Department of Education (MSDE), Division of Student and School Support, School Health Services Program
- American Academy of Pediatrics (AAP), Maryland Chapter
- Medical and Chirurgical Faculty of Maryland (MedChi), Public Health Committee, Maternal and Child Health Subcommittee
- Medical and Chirurgical Faculty of Maryland (MedChi), Infectious Disease Committee

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Use of this document:

The intent of this document is to provide general guidance to school health services personnel, child care providers, youth camp owners/operators about common communicable diseases. It is not intended for use as a diagnostic guide. Please consult a health care provider for any situations which require medical attention. This guidance is to be used in conjunction with School Health Services (SHS) guidance and local health department (LHD) policies and procedures, and applies to individual or sporadic cases of the communicable diseases described below. Outbreaks or unusual situations may require additional control measures to be instituted/implemented in consultation with your local health department. The procedures in this document represent measures specific to school, child care or youth camp settings. References to SHS Guidelines are intended for use by schools in programs serving school-aged children.

If a child's health care provider (HCP) provides exclusion recommendations which conflict with these guidelines, please consult with your local health department. If parents have additional questions, they should contact their HCP or local health department.

This document is intended to guide the development of specific local policy and procedures regarding management of communicable diseases in schools, child care, and youth camps. These policies and procedures should be implemented in collaboration and in consultation with local health departments, school health services programs, local child care authorities and youth camp regulatory authorities.

Definitions:

Outbreak: In general, an outbreak is defined as an increase in the number of infections that occur close in time and location, in a facility, such as a school, child care center, or youth camp, over the baseline rate usually found in that facility. Many facilities may not have baseline rate information, if you have questions, please contact your local health department about whether a particular situation should be considered an outbreak. In some cases, the health department may require longer exclusions than stated in this guide in response to an outbreak.

Reportable disease/condition: Maryland statute, Maryland Code Annotated, Health-General ("Health-General") §18-201 and §18-202, and Maryland regulation, Code of Maryland Regulations ("COMAR") 10.06.01.04 "Communicable Diseases" and 10.16.06.25 "Certification for Youth Camps", require that health care providers, school and child care personnel, masters of vessels or aircraft, medical laboratory personnel, owners/operators of food establishments, and owners/operators of youth camps, submit a report in writing or notification by telephone of diagnosed or suspected cases of specified diseases to the Commissioner of Health in Baltimore City or the health officer in the county where the provider cares for that person. A list of reportable diseases and conditions can be found at http://ideha.dhmh.maryland.gov/reportable-diseases.aspx

Infection control measures: Includes the use of one or of combinations of the following practices. The level of use will always depend on the nature of the anticipated contact:

- Handwashing, the most important infection control method
- Use of protective gloves, latex-free gloves are recommended*
- Masks, eye protection and/or face shield
- Gowns
- Proper handling of soiled equipment and linen
- Proper environmental cleaning
- Proper disposal of sharp equipment (e.g., needles)
- Isolation in a separate area for those who cannot maintain appropriate cleanliness or contain body fluids

***** Latex allergy is recognized as an issue for some children, especially those with multiple past surgeries. Latex-free gloves are preferred.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Fever: For the purposes of this guidance, fever is defined as a temperature >100.0° F orally; an oral temperature of 100° F is approximately equivalent to 101° F rectally or temporally (Temporal Artery Forehead scan), or 99.5° F axillary (armpit).
Diarrhea: Loose or watery stools of increased frequency that is not associated with change in diet.
Vomiting: Two or more episodes of vomiting in a 24 hour period.

General Considerations:

Exclusion: Children may be excluded for medical reasons related to communicable diseases or due to program or staffing requirements. In general, children should be excluded when they are not able to fully participate with the program, or in the case of child care settings, when their level of care needed during an illness is not able to be met without jeopardizing the health and safety of the other children, or when there is a risk or spread to other children that cannot be avoided with appropriate environmental or individual management. For exclusion, all applicable COMAR regulations should be followed; for youth camps, specifically COMAR 10.16.06.31 "Exclusion for Acute Illness and Communicable Disease".

Fever: A child may have a fever for many reasons. If a child has a fever, all applicable COMAR regulations should be followed. In addition, any child with a fever and behavior changes or other symptoms or signs of an acute illness should be excluded and parents notified. Once diagnosed, exclusion due to fever should be based on disease-specific guidelines or other clinical guidance from the child's health care provider. Also, it is important to be sure the appropriate method for measuring temperature is used based on the age or developmental level of the child.

An unexplained fever in any child younger than 3 months requires medical evaluation. Fever in an infant the day following an immunization known to cause fever, may be admitted along with health care provider recommendations for fever management and indications for contacting the health care provider. Instructions from the health care provider should include: the immunizations given, instructions for administering any fever reducing medication, and medication authorizations signed by the parent and the health care provider.

Diarrhea: Diarrhea may result in stools that are not able to be contained by a diaper or be controlled/contained by usual toileting practices. An infectious cause of diarrhea may not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of diarrhea should be sought.

A child with diarrhea should be excluded if:

- Stool is not able to be contained in a diaper or in the toilet, or child is soiling undergarments
- Stool contains blood
- Child is ill or has any signs of acute illness
- Diarrhea is accompanied by fever
- Child shows evidence of dehydration (such as reduced urine or dry mouth)

With appropriate documentation, a child with diarrhea may be readmitted to care, school, or camp when:

- An infectious cause of diarrhea (see chart) has been treated and the child is cleared by a health care provider, in conjunction with the local health department, if necessary
- The diarrhea has been determined by the local health department to not be an infectious risk to others

Vomiting: An infectious cause of vomiting may not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of vomiting should be sought. Child should be excluded until vomiting resolves or until a health care provider clears for return (is not contagious).

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
BITES, ANIMAL	N/A	Redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact.	N/A	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria. It is strongly recommended that there be medical follow-up. For school age children, see *SHS "Guide for Emergency Care in Maryland Schools, 2005"*. For preschool age children, contact the child's health care provider.	After immediate needs of bitten victim(s) are taken care of, notify local health department and appropriate local authority (police, sheriff, animal control) immediately by telephone. *[Also, see section for "Rabies".]*
BITES, HUMAN	N/A	Redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact.	N/A	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria. It is strongly recommended that there be medical follow-up. For school age children, see *SHS "Guide for Emergency Care in Maryland Schools, 2005"*. For preschool age children, contact the child's health care provider.	After immediate needs of bitten victim(s) are taken care of, notify Responsible authority and parent/guardian. Assess immunization status of children involved, including tetanus and Hepatitis B vaccination. *[Also, see SHS "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting, 2007".]*

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
CHLAMYDIA (*Chlamydia trachomatis*)	Usually 7-14 days; up to 30 days.	May be asymptomatic; genital infection can include: purulent discharge, painful urination, lower abdominal pain. Symptoms of conjunctival infection include painful, swollen eyelids.	Sexual contact: genital, oral, anal. Conjunctivitis: from infected mother to infant.	Variable, but can be a long time, if not treated.	No, exclusion is not routinely recommended.	A case or outbreak must be reported to the local health department. All cases should be referred to a health care provider for assessment (including potential for gonorrheal co-infection) and possible treatment. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. *[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]*
CMV (Cytomegalovirus, *Human herpesvirus 5*)	Variable, can be within 3-12 weeks.	Non-specific febrile illness; asymptomatic infections common. In adolescents and adults, may see fever, sore throat, fatigue, swollen glands, and mild hepatitis. In immunocompromised, may see pneumonia, colitis, retinitis.	Through mucosal contact with infected secretions or excretions (such as urine, saliva, feces, blood and blood products, breast milk, semen, cervical secretions).	Variable, may be many months or episodic for several years.	No, exclusion is not routinely recommended. Control measures: Emphasize washing hands often, especially after toileting and after diapering and handling any children less than 2 years old.	A pregnant woman or a woman who is considering pregnancy should talk to her doctor if she cares for infants or young children, or handles urine or saliva in any home or occupational setting. Pregnant women do not necessarily need to be excluded from such situations

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
COMMON COLD	12 hours to 5 days; usually 2 days.	Runny nose, watery eyes, sneezing, chills, sore throat, cough, and general body discomfort lasting 2-7 days. May also have a low-grade fever.	Direct contact with an ill person or respiratory droplets; also by contact with hands or articles contaminated with nose or throat secretions.	Variable, depending on cause; average 24 hrs before to 5 days after symptoms have started.	No, unless child meets other exclusion criteria. Do not exclude solely on the presence of runny nose regardless of the color or consistency of the nasal discharge, or presence of cough. Control measures: Emphasize covering nose and mouth when coughing/sneezing; using facial tissue to dispose of nose or throat secretions; washing hands often and not sharing eating utensils.	Many different viruses can cause the common cold.
CONJUNCTIVITIS, INFECTIOUS (Infectious Pink Eye)	Caused by bacterial or viral agents.	White or yellow discharge, accompanied by pink or red conjunctivae, redness and swelling of the lids, and matted, sticky lids.	Direct contact or through contaminated hands followed by contact with eyes; contaminated swimming pools are rarely a source of infectious pink eye.	Variable, depending on cause, from several days to weeks.	Yes, until cleared for return with documentation from a health care provider, after taking antibiotics for 24 hours, or until symptoms have resolved. Control measures: Emphasize hand hygiene.	Refer any newborn with conjunctivitis to a health care provider. NOTE: Exclusion not necessary for allergic conjunctivitis (watery eye discharge, without fever, pain, red lids, and with or without pink eye or injected conjunctivae) if evaluated and documented by a health care provider.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
DIARRHEAL ILLNESS: UNKNOWN CAUSE	Varies according to causative agent.	Varies according to causative agent. Symptoms may include nausea, vomiting, diarrhea, stomach cramps, headache, blood and/or mucus in stool, fever.	Usually spread from person-to-person by fecal-oral route; from ingesting contaminated food or water.	Duration of clinical symptoms or until causative agent is no longer present in stool.	Exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by medical provider. Control measures: Emphasize hand hygiene; observe exclusion period especially for those in activities at high risk for transmission: child care attendees, food service workers, those who care for the very young or elderly, health care workers, etc.	Report individual cases according to state health department "List of Reportable Diseases and Conditions". An outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: *CAMPYLOBACTER*	Usually 2-5 days; range 1-10 days.	Diarrhea with or without blood, abdominal pain, fever, cramps, malaise, nausea and/or vomiting.	Spread from person-to-person by fecal contact, contact with infected pets, or from ingesting contaminated foods such as raw or undercooked meats, unpasteurized milk, or untreated water.	Usually 2-3 weeks in untreated cases, up to 7 weeks.	Yes, if symptomatic until cleared by local health department after further testing. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: *E. COLI* O157:H7 and other STEC (Shiga Toxin-producing *E. coli*)	Usually 3-4 days; range 1-10 days.	Severe abdominal pain, diarrhea with or without blood and vomiting.	Spread from person-to-person by fecal-oral route or ingesting under-cooked beef, un-pasteurized milk or juices, raw fruits or vegetables, or contaminated water.	Usually 1-3 weeks.	Yes, if symptomatic until cleared by local health department. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
DIARRHEAL ILLNESS: *GIARDIA*	Usually 7-10 days; range 3 days to 4 weeks.	Acute watery diarrhea with abdominal pain, bloating, frequent loose and pale greasy stools, fatigue and weight loss.	Spread from person-to-person by fecal-oral route or ingestion of contaminated recreational/ drinking water.	Entire period of infection, often months.	Yes, until treated. If not treated, contact local health department for guidance about exclusion criteria. Control measures: Hand hygiene by staff and children should be emphasized, especially after toilet use or handling of soiled diapers; dispose of feces in a closed container; disinfection of feces-soiled articles.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: NOROVIRUS	Usually 24-48 hours; range 12-72 hours.	Nausea, vomiting, abdominal cramps, diarrhea, fever, headache.	Spread from person-to-person by fecal contact or from ingesting contaminated foods. Commonly from contaminated surfaces, objects. Possible transmission via aerosolized particles.	At least 48 hours after symptoms resolve. Sometimes longer.	Yes, until 48 hours after resolution of symptoms. Control measures: Emphasize handwashing after use of bathroom or changing diapers and thorough environmental cleaning.	An outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: ROTAVIRUS	Range approx. 1-3 days.	Vomiting, fever and watery diarrhea.	Spread from person-to-person by fecal-oral route. Possible airborne transmission.	At least 48 hours after symptoms resolve. Sometimes longer in persons with weakened immune systems.	Yes, until 48 hours after resolution of symptoms. Control measures: Vaccine-preventable. Emphasize handwashing after use of bathroom or changing diapers and thorough environmental cleaning.	An outbreak must be reported to the local health department. NOTE: Vaccine available as of 2007.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
DIARRHEAL ILLNESS: *SALMONELLA*	Usually 12-36 hours; range 6-72 hours.	Diarrhea, fever, abdominal cramps, nausea, vomiting, headache.	Ingestion of contaminated foods, including poultry, beef, fish, eggs, dairy products or water; also contact with infected reptiles.	Throughout the course of infection; extremely variable, usually several days to several weeks.	Yes, for children in child care if not toilet trained, whether symptomatic or not. Asymptomatic school age children generally do not need to be excluded. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: *SHIGELLA*	Usually 1-3 days; range 1-7 days.	Abdominal cramps, fever, diarrhea with blood and mucous; also watery diarrhea. Sometimes nausea or vomiting.	Direct or indirect fecal-oral transmission from a symptomatic patient or asymptomatic carrier; ingestion of contaminated water or food.	During acute infection and up to 4 weeks after illness.	Yes, for those who are symptomatic until cleared by local health department after further testing. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIPHTHERIA (*Corynebacterium diphtheriae*)	Usually 2-5 days; range 1-10 days.	Patches of grayish membrane with surrounding redness of throat, tonsils, nose, and/or mucous membranes. May include nasal discharge, sore throat, low grade fever, hoarseness, barking cough. Less common sites of infection: skin, eyes, ears, and vagina.	Spread from person-to-person by contact with respiratory secretions or skin lesions. Rarely, transmission may occur from articles soiled with discharges from lesions of infected persons.	Variable; usually 2-4 weeks or until 5 days after antibiotic therapy has been started.	Yes, until cleared by local health department. Contact the local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported immediately to the local health department by telephone. Rarely seen in Maryland.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
FIFTH DISEASE (Erythema infectiosum, Parvovirus B19)	Variable, 4-20 days.	Red, patchy facial rash ("slapped cheek") that may spread to rest of body in lace-like pattern. Cold-like symptoms may precede rash. May be asymptomatic.	Spread from person-to person by respiratory secretions; by contaminated blood or blood products; from mother to fetus.	Most infectious before the onset of rash in most cases.	No, exclusion is usually not necessary. Contact health care provider and/or local health department about special recommendations for infected persons with chronic anemia at risk for hemolytic complications (such as sickle cell disease), weakened immune systems, or for pregnant women. Control measures: Encourage hand washing and disinfection of surfaces, high-contact items, such as doorknobs, and items shared among children.	An outbreak must be reported to the local health department. Pregnant women exposed to a case of Fifth disease should consult with their health care provider.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
GONORRHEA (*Neisseria gonorrhoeae*, *Gonococcus)*	1-14 days, sometimes longer.	Males: Cloudy or creamy discharge from penis, pain with urination. Females: usually no symptoms, but may have vaginal discharge, urinary frequency, abdominal pain. Both genders: throat and anorectal infections (although uncommon) may produce discharge, localized pain. (Gonococcal infection can infrequently cause achy, swollen joints; a skin rash; fever; and other symptoms.	Spread from person-to-person by genital, oral or anal sexual contact.	Variable, but can be a long time, if not treated.	No, exclusion is not routinely recommended. Cases should contact a health care provider, and referred to the local health department for follow-up.	A case or outbreak must be reported to the local health department. All cases should be referred to a health care provider for assessment (including potential for chlamydial co-infection) and possible treatment. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. *[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]*
***HAEMOPHILUS INFLUENZAE* type B (HIB) DISEASE**	Unknown; may be 2-4 days.	Various, depending on site of infection: ear, eye, skin, lungs, joints, or spinal fluid spaces.	Airborne droplets produced by coughing or sneezing or contact with nose or throat discharges of an ill person or carrier; or by direct person-to-person contact.	Non-communicable 24-48 hours after the start of appropriate antibiotic treatment. Contact local health department for guidance.	Yes, exclude for 24 hours after the initiation of antibiotic therapy. Control measures: Vaccine-preventable. Vaccination is the key preventive measure. Contact local health department for recommendations about the need to exclude those who are unvaccinated, or administer prophylaxis to contacts.	A case or outbreak must be reported to the local health department immediately by telephone.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
HAND, FOOT AND MOUTH DISEASE (various Coxsackie-viruses)	Usually 3-5 days. Lesions may persist from 7-10 days	Fever, cold symptoms, rash on palms, fingers and soles, sores in mouth. Occasionally appear on the buttocks.	Spread through direct person to person contact with nose, and throat discharges, and feces of an infected person.	Highly contagious during the acute phase. Shedding in stool may continue for several weeks.	No, unless meets other exclusion criteria, "hand to mouth" behavior uncontrollable, not able to contain secretions, or draining sores cannot be covered. Control measures: Avoid person-to-person contact with ill person. Emphasize washing hands often and not sharing eating utensils, also for caretaker of ill infants and diapered children. Wash or discard items of clothing contaminated with nose or throat discharges or with fecal material.	An outbreak must be reported to the local health department.
HEPATITIS A	Usually 28 days after exposure; range 15-50 days.	Early symptoms: fatigue, loss of appetite, stomach pain, diarrhea, nausea, vomiting, fever, dark urine. Later symptom: jaundice (yellow skin and eyes). Some cases are mild. Children may be asymptomatic.	Spread from person-to-person by fecal contact; or from ingesting food or water containing the virus.	Usually a 3-week period: from 1 week before onset of early symptoms to 1 week after onset of jaundice. Prolonged viral excretion (up to 6 months) has been documented in infants and children.	Yes, for at least 2 weeks after the onset of early symptoms or 1 week after onset of jaundice. Control measures: Vaccine-preventable. Emphasis on hand-washing after use of bathroom or changing diapers and (if necessary) improved disinfection. Food handlers or servers should refrain from preparing or serving food for 2 weeks after onset of early symptoms.	A case or outbreak must be reported to the local health department.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
HEPATITIS B	Usually 60-90 days; range 45-180 days.	Dark urine, fatigue, loss of appetite, nausea, vomiting, often followed by jaundice. Joint pain may be present. Some cases are mild. Children may be asymptomatic.	Spread by exposure to infected blood; injection drug use; from mother to infant during pregnancy or birth; sexual contact; and through other body fluids.	Several weeks before onset of symptoms and during course of acute disease. Persons with a positive hepatitis B surface antigen (HBsAg) test are considered communicable, even years after initial infection.	No, exclusion is not routinely recommended unless the individual is not able to resume activities. However, exclusion could be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure	A case or outbreak must be reported to the local health department. Pregnant women who are HBsAg positive should be referred to their health care provider.
HEPATITIS C	Ranges from 2 weeks to 6 months; commonly 6-9 weeks.	Loss of appetite (weight loss), nausea, vomiting, jaundice, dark urine, fatigue, & vague abdominal discomfort may occur. However, may be asymptomatic.	Exposure to infected blood: primarily parenterally (through injection drug use, accidental contaminated sharps exposure). Sexual and perinatal transmission appear rare. Rarely through other body fluids.	One or more weeks before the onset of symptoms; some persons become carriers and remain infected indefinitely.	No, exclusion is not routinely recommended unless the individual is not able to resume activities. However, exclusion could be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact local health department for further guidance.	A case or outbreak must be reported to the local health department.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
HERPES SIMPLEX VIRUS (Cold Sores, Fever Blisters, genital herpes sores, skin lesions)	Usually 2-12 days	Oral herpes: sores or blisters on the lips or mouth. Genital herpes: painful sores or blisters in the genital area. Herpes gladiatorum: Sores on exposed areas of skin.	Spread from person-to-person by direct contact with saliva, sores, or blisters, such as touching, kissing, or having sex; perinatally.	Virus can be recovered from lesions 2-7 weeks after primary infections and up to 5 days in reactivation lesions	Oral herpes: No, unless child with oral herpes is drooling and can not contain secretions or meets other exclusion criteria. Genital herpes: No, unless meets other exclusion criteria. Herpes gladiatorum: Yes, exclusion from contact sport participation that requires skin-skin contact. Control measures: Handwashing and avoid touching lesions. Cover lesions if possible. Disinfection of sporting equipment after use. Avoid sharing sports equipment that comes in contact with skin.	Pregnant women with herpes should consult a health care provider. Stress handwashing and not touching lesions. An outbreak must be reported to the local health department.
HIV (Human Immunodeficiency Virus) infection, includes AIDS	Variable; 1-3 months from infection to detection of antibodies. Median incubation in infected infants is shorter than adults	May be asymptomatic for many years. Symptoms in later stages of HIV infection are variable.	Spread from person-to-person through sexual contact; exposure to HIV-infected blood or body fluids (e.g., dirty needles); from mother to infant during pregnancy, or birth.	Soon after onset of infection and persists throughout life. Infectivity is high during first months; increases with viral load; worsening of clinical status; and presence of other sexually transmitted infections. Treatment may reduce communicability.	No, unless meets other exclusion criteria, has weeping and oozing sores that can not be covered, bleeding condition where blood can not be contained; if so, consult local health department. Control measures: Responsible sexual behavior (abstinence or condom use). Avoidance of blood and sharps exposures.	Staff who routinely provide acute care should wear gloves and use good handwashing technique. Standard precautions should be followed by all health care personnel. *[Also, see SHS "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting, 2007".]*

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
INFLUENZA (Seasonal)	Usually 1-3 days.	Cough, fever, headache, muscle aches, runny nose, sore throat. Less frequently, GI symptoms.	Person to person by droplets or direct contact with infected articles.	24 hours before the onset of symptoms and up to 7 days in young children.	Yes, until without fever for 24 hours, or if meets other exclusion criteria. Follow local health department recommendations. Control measures: Vaccine-preventable. Emphasize respiratory etiquette and frequent handwashing.	An outbreak must be reported to the local health department. Do not use salicylates (such as aspirin) during illness.
IMPETIGO ("SKIN INFECTIONS", Staphylococcal or Streptococcal skin infections)	Variable. Usually 4-10 days.	Blister-like skin lesions, which later develop into crusted sores with an irregular outline.	Direct contact with draining sores or by touching articles contaminated with blister fluid.	Usually not contagious after 24 hours of treatment.	No, if lesion can be covered. Yes, if lesion cannot be covered. If antibiotic therapy indicated, exclude until 24 hours of antibiotic therapy has been completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotics indicated, exclude until lesion is healed. For contact sports: Yes, if lesion cannot be covered, regardless of whether antibiotics started, until lesion is healed. Control measures: Avoid touching lesions. Emphasize frequent hand-washing. Conduct routine environmental cleaning.	Cases with lesions should avoid contact with newborns. *[See also sections for "Staphylococcal Infection" and "Streptococcal Infection."]*

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
LICE, BODY (*Pediculus corporis*)	6-10 days from laying of eggs to hatching of nymphs.	Intense itching, worse at night. Lice live in seams of clothing and may or may not be visible.	Direct contact with an infested person or contact with objects used by an infested person, especially clothing.	As long as lice are alive on infested person or object. Eggs viable on clothing 1 month. Adult lice viable away from host up to 10 days.	Yes, at the end of the program/activity/school day. Skin may need treatment with pediculicide -- if one is used, exclude for 24 hours after first treatment is completed. Control measures: Bathe with soap and water. Wash clothing and bedding in hot water and dry on high heat or dust clothing with a pediculicide.	An outbreak must be reported to the local health department. Body lice may transmit serious infections.
MEASLES (Rubeola)	Usually 8-12 days from exposure to onset of symptoms. Average interval between appearance of rash after exposure is 14 days; range 7-18 days.	Sudden onset of chills followed by sneezing, runny nose, conjunctivitis, photophobia, fever, cough. Rash usually appears first behind the ears or on forehead/ face; blotchy, unusually dusky red rash over face, trunk, and limbs. Small white spots (Koplik's spots) inside mouth.	Direct contact with infectious droplets or, less commonly, by airborne spread. Highly contagious among unvaccinated children in school, child care or camp settings.	1-2 days before onset of symptoms (3-5 days before rash) to 4 days after appearance of the rash. Immuno-compromised children can be contagious for the duration of the illness.	Yes, until 4 days after the onset of rash in otherwise healthy children and for the duration of illness in immunocompromised children. Contact local health department for further guidance on management of cases and contacts. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Pregnant women exposed to a case should see a health care provider for evaluation.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MENINGITIS, VIRAL or ASEPTIC (including Enterovirus, Measles, Herpes, Adenovirus)	Varies depending on specific viral agent. Usually within 3-10 days later.	Fever, severe headache, stiff neck, bright lights hurting the eyes, drowsiness or confusion, and nausea and vomiting may occur. Meningitis symptoms are an emergency that should be assessed immediately be a health care provider.	Varies depending on specific viral agent. Most common cause: Enteroviruses, most often spread through direct contact with respiratory secretions.	Depends on the viral agent causing illness, but usually (Enteroviruses) 3 days after infected until about 10 days after developing symptoms.	Yes, until cleared for return by health care provider or local health department. Contact local health department for guidance. Contacts of cases generally do not need to be seen by a health care provider or given preventive medications. Control measures: Emphasize handwashing after use of bathroom, changing diapers, and before handling or eating food or drink.	A case or outbreak must be reported to the local health department. Most viral infections do not require treatment; however, some may require specific antiviral therapy.
MENINGITIS, BACTERIAL (*Haemophilus influenzae*, *Neisseria meningitidis*, *Streptococcus pneumoniae*, *Listeria*)	Varies depending on specific bacterial agent, but usually 2-10 days, commonly 3-4 days.	Fever, stiff neck, headache, vomiting, and rash may occur. Meningitis symptoms are an emergency that should be assessed immediately be a health care provider.	Direct contact, including respiratory droplets from nose and throat of infected people, but it varies depending on the bacterial agent causing illness.	Depends on the bacterial agent causing illness.	Yes, until cleared by health care provider in conjunction with local health department. Contact local health department for guidance. Some agents may require antimicrobial therapy. Some contacts of cases may need preventive antibiotics. Control measures: Vaccine-preventable for some types of bacteria that can cause meningitis (*Haemophilus influenzae*, *Neisseria meningitidis*, *Streptococcus pneumoniae*). Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MENINGOCOCCAL DISEASE (*Neisseria meningitidis*)	Usually 3-4 days; range 1-10 days.	Sudden onset with fever, vomiting, intense headache, and stiffness of the neck. A rash may appear on the body. Other symptoms sometimes seen with non-meningitis forms of the disease.	Spread by close contact with droplets and discharge from nose, throat or saliva of an infected person. Illness highly contagious in child care settings.	Usually 24 hours after the initiation of appropriate therapy	Yes. Refer case to health care provider. Control measures: Follow local health department recommendations for prophylaxis and surveillance for close contacts, including household, child care contacts, others with saliva contact with case. A vaccine is available for certain types of meningococcal disease, and is required by law for certain risk groups. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone.
MOLLUSCUM CONTAGIOSUM	Usually 2-7 weeks; range 7 days to 6 months.	Smooth surfaced, spherical papules on skin, sometimes appears in linear orientation, can be itchy. In children, lesions most often seen on face, trunk, extremities.	Usually through direct contact. Possible sexual transmission or via fomites. Some autoinoculation.	Unknown. Probably as long as lesions persist.	No, exclusion not routinely recommended. For contact sports or sports with shared equipment that comes in contact with skin (such as gymnastics, etc.): No, as long as lesions/bumps can be covered with clothing or a watertight bandage.	An outbreak must be reported to the local health department. Genital lesions in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MONONUCLEOSIS, INFECTIOUS (Epstein-Barr virus)	Usually 30-50 days.	Fever, sore throat, swollen lymph nodes, sometimes rash. Neurologic complications include: meningitis, encephalitis, myelitis.	Spread by close personal contact via saliva; also may be transmitted by blood transfusion.	Prolonged; may be up to a year or more. Some may be long-term carriers.	General exclusion: No, exclusion not routinely recommended. Contact sports: Yes, until acute illness is resolved and cleared by a health care provider. Control measures: Use general hygienic measures, including handwashing to prevent salivary contamination from infected individuals; minimize contact with saliva (such as, avoiding drinking beverages from a common container).	An outbreak must be reported to the local health department. Regarding contact sports, health care provider must clear athletes to reduce risk of splenic rupture.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MUMPS	Usually 16 to 18 days; range 12 to 25 days.	Fever, swelling, tenderness of the salivary gland; may be asymptomatic. Parotid glands most frequently affected. Meningitis may occur. In males after puberty, testicular involvement may occur.	Spread by droplet contact and direct contact from nose and throat discharge of an infected person. Highly contagious among unvaccinated children in school, child care, or camp settings.	From 3 days before salivary gland enlargement to 5 days after.	Yes. Exclude case for 5 days after onset of parotid gland swelling. Refer case to health care provider and contact local health department for guidance managing contacts of cases. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department.
PERTUSSIS (*Bordetella pertussis,* Whooping Cough)	Usually 7-10 days; range 5- 21 days.	Acute onset of cough becomes repeated and violent within 1-2 weeks, can persist for several months. Characteristic thick mucus and vomiting after coughing. May not have the typical inspiratory "whoop". Fever may be low-grade or absent.	Spread by close contact with infected persons via aerosolized droplets.	Beginning from just before onset of symptoms to up until 3 weeks after start of symptoms.	Yes, consult with local health department. Confirmed cases should be excluded until completion of 5 days of recommended antibiotics. Untreated cases should be excluded 21 days from the date cough began. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Highly contagious among unvaccinated children in school, child care, or camp settings. Infants, elderly and immunocompromised individuals at increased risk for complications.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
PINWORMS (*Enterobius vermicularis*)	The life cycle of the worm is 2-6 weeks.	Perianal itching (usually worse at night), irritability, disturbed sleep, secondary infection of the scratched skin.	Transfer of *Enterobius* eggs from fingers of infected person to mouth of uninfested person.	Eggs are communicable in the environment at room temperature about 2-3 weeks.	No, exclusion is generally not recommended. Control measures: Encourage frequent hand-washing. Keep nails short; discourage nail biting and perianal scratching. Daily for several days after treatment: change to clean underwear and bed sheets after bathing, wash linens in hot (131°F) water, clean and vacuum living and sleeping areas.	This should be handled and on a case-by-case basis by the appropriate school or regulatory authority.
PNEUMOCOCCAL DISEASE (*Streptococcus pneumoniae*)	Varies depending on type of infection. May be as short as 1-3 days.	Various symptoms, depending on location of infection: ear, eye, sinus, lungs, blood, joints, or spinal fluid spaces. May cause meningitis.	Person-to-person transmission through contact with respiratory droplets.	No longer communicable 24-48 hours after initiation of appropriate antibiotics.	No, exclusion is not routinely recommended. Contact local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	Outbreaks or cases of invasive disease must be reported to the local health department.
POLIO	3-6 days for mild (nonparaly-tic) cases; 7-21 days for paralytic cases.	Infection may be asymptomatic, cause mild illness (fever, malaise, headache, vomiting), or severe illness (meningitis, muscle paralysis, death).	Spread by contact with nose or throat discharge, or by fecal-oral contamination.	Shortly before onset of clinical illness to several weeks after. Children are contagious as long as virus is excreted in feces, usually for several weeks.	Yes, exclude case until health department approves readmission. Contact local health department for guidance of acute cases and contacts. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RABIES (and RABIES EXPOSURE)	Varies: days to years	Human: Apprehension, fever, difficulty swallowing, hypersalivation, muscle weakness, hydrophobia, sensory changes (e.g. tingling) or paralysis, delirium, convulsions, death due to respiratory paralysis. Animal: Unusual behavior changes (stupor or aggression), increased salivation, paralysis. Death in 2-7 days from onset of illness.	Primarily via bite from a rabid animal. Non-bite exposures include scratches, abrasions, and saliva contamination of open wounds or mucous membranes, or organ transplantation.	Human-to-human bite transmission does not generally occur. In dog and cats, approximately 3-7 days before clinical signs appear and throughout course of disease.	No, exclusion is not recommended for rabies exposure alone. Control measures: Do not let children play with strange, unknown animals or have contact with wild animals, especially bats. If a person is exposed to a possibly rabid animal, immediately wash wound thoroughly with soap and water for several minutes. Seek emergency medical attention immediately, if child was bitten. For school age children, see *SHS "Guide for Emergency Care in Maryland Schools, 2005"*. For preschool age children, contact the child's health care provider. Contact local health department to assess need for post-exposure prophylaxis.	Any case or suspected exposure must be reported immediately by telephone to local law enforcement and local health department. Confine biting animal (if it is safe to do so) or as advised by local law enforcement, and local health department or animal control, for possible testing or quarantine. *[Also, see section for "Bites, Animal".]*

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RINGWORM OF SCALP (*Tinea capitis*)	Usually 10-14 days.	Patchy areas of dandruff-like scaling and hair loss; many separate blisters, with pus in them with little hair loss; or a soft, red, swollen area of scalp.	Contact with the skin of an infected person or animal, or by contact with contaminated surfaces or objects such as combs, furniture, clothing, and hats. People may be asymptomatically infected yet able to transmit disease.	May persist on contaminated materials for a long time if untreated.	Yes, until oral treatment has been initiated. Yes, exclude from contact sports involving skin-skin contact. Control measures: Cover lesions if necessary to prevent direct contact. Disinfect sports equipment that comes in contact with skin. Avoid sharing sports equipment that comes in contact with skin. Examine household, child care, school, camp, and animal contacts; treat if infected. Do not share combs, brushes, hair ornaments, hats, or linens while being treated. Haircuts or shaving the head is not needed. Selenium-containing shampoo twice a week limits shedding of fungus. Head lesions may not be able to be covered. This should be handled on a case-by-case basis.	Recommended treatment for ringworm of the scalp is oral medications because topical medications are not effective against ringworm of the scalp. Topical medications are considered effective for non-scalp ringworm.

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RINGWORM OF SKIN OR BODY (*Tinea corporis*)	Usually 4-10 days.	Lesions are usually circular or ring-like, slightly red with a raised edge, and appear on the face, trunk, or extremities. May itch.	Contact with lesions or with contaminated surfaces such as floors, showers, or benches.	While lesions are visible. Fungus may persist for long periods on contaminated surfaces.	No, as long as lesions can be covered, and oral or topical treatment has been initiated. Routine exclusion is not recommended. Yes, exclude from contact sports involving skin-skin contact. Control measures: Cover lesions to prevent direct contact. Disinfect sports equipment that comes in contact with skin. Launder towels, linens and clothes in hot water. Refer school, child care, or camp contacts to their health care provider. Examine skin for resolution of lesions.	Topical medications are considered effective for non-scalp ringworm.
ROSEOLA (Human herpesvirus 6, Exanthem subitum, Sixth Disease)	Usually 10 days; range 5-15 days.	Fever, rash (small flat pink spots or patches) usually on the chest, back, abdomen, neck and arms, not usually itchy.	Direct contact with salivary secretions.	Unknown.	No, unless meets other exclusion criteria. No specific control or preventive measures indicated.	An outbreak must be reported to the local health department.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RSV (Respiratory Syncytial Virus)	Usually 4-6 days; range 2-8 days.	Acute respiratory tract illness.	Direct or close contact with contaminated secretions (via droplets or objects).	Period of viral shedding usually 3-8 days, but may last longer in young infants and those who are immunosuppressed .	No, unless meets other exclusion criteria. Follow local health department recommendations. Control measures: Cohort those with respiratory illness, emphasize handwashing hygiene, contact precautions where indicated.	An outbreak must be reported to the local health department.
RUBELLA (German measles)	Usually 16-18 days; range 14-23 days.	Mild illness with low fever, mild rash, usually associated with enlargement of nodes on the back of the neck. Rash usually follows 5-10 days later; may resemble measles, scarlet fever, or fifth disease.	Spread by droplet contact and direct contact from nose and throat discharge of an infected person, and possibly from blood and urine; from mother to infant during pregnancy.	Maximal communicability is from a few days before to 7 days after onset of rash. Those children with congenital rubella syndrome may be infectious for up to 1 year. Highly communicable.	Yes, exclude for 7 days after rash onset. With outbreaks, exclude unimmunized individuals until they are immunized. Contact local health department for guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Infection during pregnancy may have serious consequences for the fetus. For recommendations for children with congenital rubella syndrome, contact local health department. Caregivers of these infants should be aware of the potential hazard of the infants to susceptible pregnant contacts.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
SCABIES	2-6 weeks before onset of itching; 1-4 days for those reinfested.	Rapid onset of red papular rash, with or without white scaling, involving the fingers, wrists, elbows, knees, abdomen and other skin surfaces. Intense itching, especially at night. A classic burrow, mite, or egg seen on skin scraping is diagnostic.	Person-to-person through direct skin-to-skin contact such as holding hands or sexual contact or through direct contact with contaminated clothes, bedding, and personal articles.	Until mites or eggs are destroyed, usually after 24 hours of effective therapy. Mites usually die if away from host for more than 2-3 days.	Yes, until after treatment is administered, usually the overnight. Treat case with scabicide and follow medical advice from health care provider. Treat household and close contacts at same time as case. Clothing, bedding and other personal articles used in the 3 days before treatment should be laundered using hot cycles of washer and dryer, or dry-cleaned.	An outbreak must be reported to the local health department. Mites do not transmit any other communicable disease. Itching may persist for weeks following effective treatment due to allergic reaction; bacterial infections of skin can result from scratching.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
STAPHYLOCOC-CAL INFECTION ("Staph", Impetigo), including MRSA, (Methicillin-resistant *Staphylococcus aureus*)	Variable and indefinite	Skin and soft tissue infections, such as impetigo, boils, or skin abscesses, occasional invasive disease (ex: wound infections, bloodstream infections, pneumonia)	Direct person to person contact, usually on hands. Possible transmission via air, contaminated surfaces, objects. Non-intact skin increases risk.	As long as purulent lesions continue to drain but sporadic cases occur due to asymptomatic carrier state.	No, if lesion can be covered. Yes, if lesion cannot be covered. If antibiotic therapy is indicated exclude until 24 hours of antibiotic therapy has been completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotic therapy indicated, exclude until lesion is healed. For contact sports: Yes, if lesion cannot be covered, regardless of whether antibiotics have been started, until lesion is healed. Control measures: Avoid touching lesions. Emphasize frequent handwashing. Conduct routine environmental cleaning.	Colonization alone with Staph, including MRSA, is not a reason for exclusion. Contact local health department for guidance. An outbreak must be reported to the local health department. Antibiotic treatment may not be indicated for every case of Staph infection, including MRSA. *[Also, see section for Impetigo ("Skin Infections").]*

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STREPTOCOCCAL INFECTION (Strep Throat, Scarlet Fever, Impetigo)	1-3 days, can be up to 5 days; variable for skin infections	Fever and sore throat/tonsillitis with tender, enlarged lymph nodes. Scarlet fever -- sore throat, fever, plus a red rash that feels like sandpaper and lasts 2-5 days. Tongue may appear strawberry-like. When rash fades, skin peels from tips of fingers and toes.	Spread from person to-person by respiratory droplets, by direct contact and rarely by contact with objects contaminated with nose or throat secretions. Carriers capable of spreading illness. May be foodborne via contaminated milk or eggs.	10-21 days if untreated. Until 24 hours after start of antibiotic treatment.	Yes, exclude case until 24 hours after start of antibiotic treatment. Control measures: Emphasize respiratory etiquette ("cover your cough") and frequent handwashing.	An outbreak must be reported to the local health department. Early recognition and treatment can prevent serious complications. *[Also, see section for Impetigo ("Skin Infections").]*
SYPHILIS	Usually about 3 weeks; range 10 days to 3 months.	May be asymptomatic; painless ulcer on genitals, anus, or mouth. Rash on palms and soles, generalized rash, or generalized lymph node swelling appear in secondary stage.	Spread by genital, oral or anal sexual contact with an infected person; from mother to infant during pregnancy or at delivery.	Up to one year if untreated but recurrences of lesions may persist.	No, exclusion not routinely recommended, however, should be managed by a health care provider. Case should be treated with antibiotics, and sexual contacts examined and treated with preventive antibiotics.	A case or outbreak must be reported to the local health department. Untreated, syphilis (even with no initial symptoms) can cause serious damage to heart, brain and other organs. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. *[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]*

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TICKBORNE ILLNESSES: (*Anaplasmosis, Ehrlichiosis, Lyme Disease, Rocky Mountain Spotted Fever*, etc.)	Usually 7-10 days; range 3-32 days after tick bite.	Fever, headache, lack of appetite, nausea, vomiting, muscle aches, chills. Possible rash, conjunctivitis, or meningo-encephalitis.	Tick bite; rarely through blood transfusion	No documented person-to-person transmission.	No, exclusion is not necessary. Control measures: Avoid exposure to ticks; wear protective light-colored, long sleeve shirts and pants; use insect repellents; conduct tick checks. Remove embedded ticks promptly with tweezers. Consult a health care provider if symptoms occur.	A case must be reported to the local health department. Tick-borne diseases carry the risk of more severe and/or chronic illness for immunocompromised persons. Pregnant women bitten by a tick should consult with their health care provider.
TUBERCULOSIS (TB, *Mycobacterium tuberculosis*)	Generally 2-10 weeks after exposure to someone with **active** TB who is infectious.	Fever, weight loss, malaise, cough and night sweats are common, but some individuals have no symptoms at all. Children younger than 5 years are more likely to present with weight loss, malaise, and failure to thrive.	Airborne: via activities such as coughing, speaking and singing.	A person diagnosed with **active** TB on appropriate antibiotics will become non-infectious in a few weeks on average; however, a person's response to treatment will vary depending on their general health and the severity of their TB disease when diagnosed. In contrast, a person with **latent** TB infection cannot infect others and treatment is not mandatory.	Yes, until treatment is started and cleared by local health department. The local TB Control Program will determine when a person with **active** TB disease may return; and will determine control measures in the school, child care, or camp setting. Children diagnosed with **latent** TB infection cannot infect others and should not be excluded. Children who have received BCG vaccine may still become infected with TB, and should not be excluded from any testing that the local health department does as part of an investigation of possible TB contacts.	A person with or suspected to have **active** TB disease must be reported immediately by telephone to the local health department. Facility must cooperate fully with the local health department in testing any other children, faculty, staff, and child care providers to determine if TB transmission has occurred. Requirements for TB testing of new students may vary from one jurisdiction to another. Consult local health department for further details.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
TYPHOID FEVER (*Salmonella typhi*)	Depends on infectious dose and on host factors, but usually 7-14 days: range 3 days to over 60 days.	Fever, headache, red ('rose') spots on the body; lack of heart rate elevation with fever; constipation more often than diarrhea.	Spread from direct person-to-person contact, or by contaminated food or water.	For as long as infected person carries in feces or urine, if untreated can be months, if carriers can be years.	Yes, for those who are symptomatic, until cleared by local health department after further testing. Contact local health department for guidance. Control measures: Vaccine-preventable. Encourage hand hygiene after toilet use, after diapering children, and before preparing or eating food.	A case or outbreak must be reported immediately by telephone to the local health department immediately by telephone.
VARICELLA ZOSTER VIRUS: CHICKENPOX (Primary varicella zoster virus infection)	Usually 14-16 days from exposure to rash, but may range from 10-21 days.	Slight to moderate fever and skin rash consisting of fluid-filled bumps (vesicles). In "ordinary" infections, "new" vesicles can continue to appear for 4-7 days. Rash is itchy; scratching can produce skin abrasions and lead to secondary infection.	Person-to-person, by respiratory or airborne droplet spread (produced by talking, coughing, or sneezing) or by direct contact with vesicle fluid or respiratory sections, or with mucous membranes of infected persons. Highly contagious. However, a susceptible person may acquire chickenpox infection if exposed to the vesicle fluid of someone with shingles.	Usually, in a "normal" case of varicella in an otherwise healthy child, period of communicability is from 1-2 days before rash appears, to when all lesions are completely crusted over (approximately 5 days). Persons who are susceptible to varicella should be considered to be infectious from 8-21 days after exposure. Persons with weakened immune systems may be communicable for longer periods.	Yes, until all lesions are completely dried or crusted over, usually 5 days after the onset of the rash. Lesions that can be fully covered are of little risk to susceptible persons. Control measures: Vaccine-preventable. Vaccination is the key preventive measure. Contact local health department for more specific recommendations, such as vaccination of unvaccinated or incompletely vaccinated individuals. Disinfect articles handled by, or contaminated with respiratory secretions or vesicular fluid from infected persons.	Reports outbreaks to local health department. Advise student's parent or guardian, or staff member, to contact health care provider after varicella exposure of neonate, during pregnancy, or of a person with a weakened immune system. *[Also, see section for "Varicella zoster virus: Shingles".]* *[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Rashes".]*

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
VARICELLA ZOSTER VIRUS: SHINGLES (also known as zoster; reactivation of prior infection with varicella zoster virus)	Reactivation of latent herpes zoster virus infection may occur years after primary infection (chickenpox) and may occur after vaccination with live virus varicella vaccine.	Vesicles with a red base appearing in the distribution of a peripheral sensory nerve (“dermatome”). Vesicles associated with either itching or severe pain. Scarring, loss of function may occur.	May also be associated with prior varicella vaccination. Zoster occurs due to reactivation of latent varicella/ zoster virus. NOTE: Fluid within zoster vesicles is infective, and indirect transmission of virus particles from vesicle fluid on contaminated clothing or other articles may occur.	From appearance of shingles vesicles until all vesicles are dried or crusted over -- about five days to a week.	Yes, until all lesions are completely dried and crusted over, or fully covered. Contact local health department for specific recommendations for contacts. Control measures: Varicella vaccine (see above) not shingles vaccine may be used in some circumstances to prevent cases of primary chickenpox in people exposed to shingles. Contact local health department for more specific recommendations. Disinfect articles handled by, or contaminated with vesicular fluid from infected persons.	Report outbreaks to local health department. Persons on cancer chemotherapy or who are HIV-infected may be at higher risk. *[Also, see section for “Varicella zoster virus: Chickenpox”.]* *[Also, see SHS “Guide for Emergency Care in Maryland Schools, 2005” section for “Rashes”.]*

ADDITIONAL INFORMATION: INFESTATIONS COMMONLY SEEN IN SCHOOLS, CHILD CARE, AND YOUTH CAMPS

Parasite	Symptoms	How do infestations occur?	Exclusion (Yes or No) and Control Measures	Additional information
BED BUGS (*Cimex lectularius*)	Itchy, skin welts occur a day after the bite. The medical concern is usually limited to itching and inflammation of the welts. Infestations may cause anxiety and loss of sleep. If badly affected, seek medical care promptly.	Bed bugs are usually carried into the home unknowingly. People carry them on luggage, clothing, beds, and furniture, especially used beds and sofas. Once inside the home, they spread from room to room. Can live for months without food or water.	If bed bugs are found on a child, the child should not be sent home early or excluded immediately. Control measures: Clothing may be placed in disposable plastic bags and then taken directly into the washer and/or dryer. For infestations of facilities, it is recommended to enlist the services of a professional pest control firm.	For additional information, refer to: <http://ideha.dhmh.maryland.gov/pdf/bed_bugs_fact_sheet_maryland_dhmh.pdf>
LICE, HEAD (*Pediculus capitis*)	Often none. Itching possible. Nits (eggs) are tightly attached to hair shaft near the scalp, often near nape of neck and behind the ears. Crawling lice rarely seen.	Direct contact with infested person's hair or occasionally their clothing, combs, brushes, carpets, or linens. Lice do not jump from person to person. Adult lice viable away from host up to 2 days.	Yes, at the end of the program/activity/school day, until after first treatment is completed. Children should not be sent home early or excluded immediately. For nits, routine exclusion not recommended. "No-nit" policies not recommended. Control measures: Notify parent/guardian to treat child with a pediculicide. Follow manufacturer's recommendation for treatment and remove nits. Do not share combs, brushes, hair ornaments, hats, or linen. Examine close contacts for lice and treat. Wash clothing, bedding, and towels in hot water and dry on high heat or dry clean or place in tightly closed plastic bag for 14 days. Vacuum furniture and rugs.	Exclusion or readmission can be determined by local policy, or on a case- by-case basis. Lice do not transmit any communicable diseases, but bacterial infections of skin can result from scratching. This should be handled and on a case-by-case basis by the local school system or regulatory authority.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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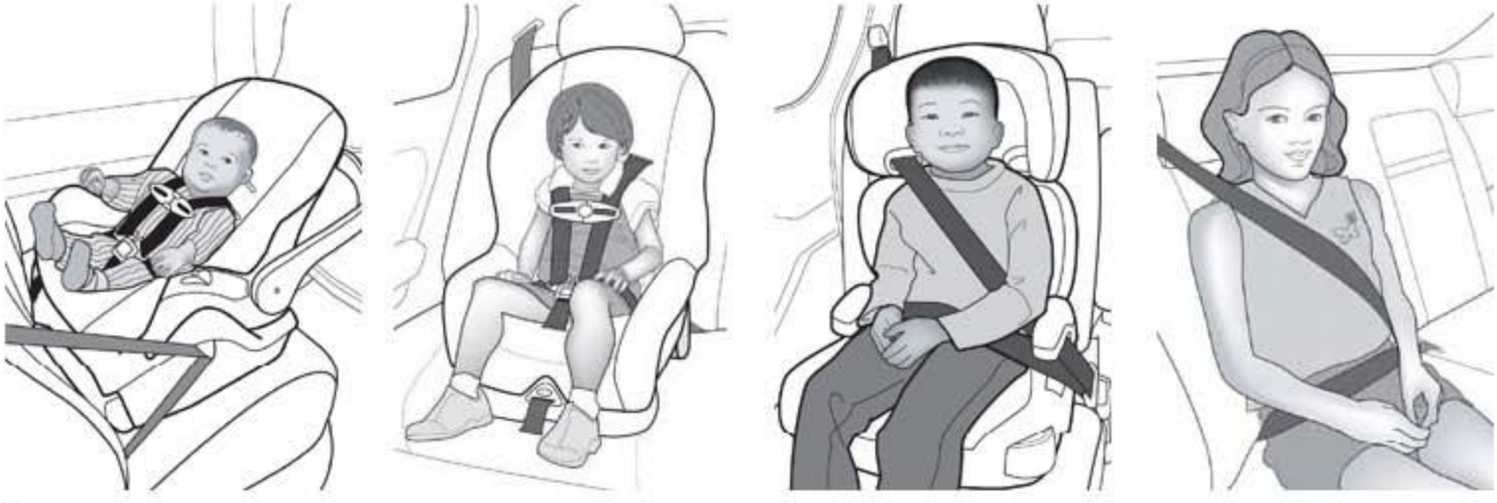
NOTES:

- *Periods of exclusion are intended for cases in school, child care, and youth camp settings*
- *Check with local health department for recommended control measures and prevention steps*
- *Additional information on these and other diseases can be found on the Internet at* <www.cdc.gov> *or* <http://ideha.dhmh.maryland.gov/SIPOR/>
- *A Directory of Local Health departments may be found at* <http://ideha.dhmh.maryland.gov/local-health-departments.aspx>

Maryland's Child Passenger Safety Law

(Effective October 1, 2013)



- **Every child** under 8 years old must ride in an appropriate child restraint* unless the child is 4 feet, 9 inches or taller.
- **Every child** from 8 to 16 years old who is not secured in a child restraint must be secured in a vehicle seat belt.

* "Child restraint" includes car seats, booster seats, or other federally approved safety devices.

Protect your children as they ride!

Children under 13 years old should ride in the back seat.

The back seat is the safest.

Questions?

Call **Maryland Kids In Safety Seats (KISS)**
at 1-800-370-SEAT or (410) 767-6016,
e-mail: *dhmh.kiss@maryland.org*
or visit us online at *www.mdkiss.org*

MARYLAND KISS
KIDS IN SAFETY SEATS

Maryland Highway Safety Office

MARYLAND
Department of Health and Mental Hygiene

Maryland KISS Program
Martin O'Malley,
Governor
Anthony G. Brown,
Lt. Governor
Joshua M. Sharfstein, M.D.,
Secretary, DHMH

Boosters Are For Big Kids

Most kids need to ride in a booster seat from about age 4 until age 10-12.

If your child isn't using a booster, try the simple test below the next time you ride together in the car. You may find that your child is not yet ready to use a safety belt without a booster.

The 5-Step Test

1. **Does the child sit all the way back against the auto seat?**
2. **Do the child's knees bend comfortably at the edge of the auto seat?**
3. **Does the belt cross the shoulder between the neck and arm?**
4. **Is the lap belt as low as possible, touching the thighs?**
5. **Can the child stay seated like this for the whole trip?**

If you answered "no" to any of these questions, your child needs a booster seat to make both the shoulder belt and the lap belt fit right for the best crash protection. Your child will be more comfortable, too!

For best protection, all children should ride in the back seat until they are ready to drive. It's twice as safe as the front seat.

***SafetyBeltSafe* U.S.A.** P.O. Box 553, Altadena, CA 91003 www.carseat.org
310/222-6860, 800/745-SAFE (English) 310/222-6862, 800/747-SANO (Spanish)

Bike Safety Tips

Everything you need to know to keep your kids safe when biking.

There are so many great reasons to ride your bike: It offers fun, freedom and exercise, and it's good for the environment. Here are a few tips so that you will be as safe as possible while you're doing it.

Wear a Helmet

- We have a simple saying: "Use your head, wear a helmet." It is the single most effective safety device available to reduce head injury and death from bicycle crashes.

Find the Right Helmet Fit

- Make sure your child has the right size helmet and wears it every time when riding, skating or scooting. Your children's helmet should meet the U.S. Consumer Product Safety Commission's standards. When it's time to purchase a new helmet, let your children pick out their own; they'll be more likely to wear them for every ride.

More children ages 5 to 14 are seen in emergency rooms for injuries related to biking than any other sport. Helmets can reduce the risk of severe brain injuries by 88 percent – yet only 45 percent of children 14 and under usually wear a bike helmet.

- Make sure the helmet fits and your child knows how to put it on correctly. A helmet should sit on top of the head in a level position, and should not rock forward, backward or side to side. The helmet straps must always be buckled, but not too tightly. Safe Kids recommends kids take the Helmet Fit Test.

- **EYES** check: Position the helmet on your head. Look up and you should see the bottom rim of the helmet. The rim should be one to two finger-widths above the eyebrows.

- **EARS** check: Make sure the straps of the helmet form a "V" under your ears when buckled. The strap should be snug but comfortable.

MOUTH check: Open your mouth as wide as you can. Do you feel the helmet hug your head? If not, tighten those straps and make sure the buckle is flat against your skin.

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Use Appropriate Helmets for Different Activities

- Children should always wear a helmet for all wheeled sports activities.
- A properly-fitted bike helmet is just as effective when riding a scooter, roller skating or in-line skating.
- When skateboarding and long boarding, make sure your child wears a skateboarding helmet.
- Proper Equipment and Maintenance Are Important
- Ensure proper bike fit by bringing the child along when shopping for a bike. Select one that is the right size for the child, not one he or she will grow into.
- When children are sitting on the seat of the bicycle, their feet should be able to touch the ground.
- Before the ride, make sure the reflectors are secure, brakes work properly, gears shift smoothly, and tires are tightly secured and properly inflated.
- Long or loose clothing can get caught in bike chains or wheel spokes. Dress young kids appropriately to ensure a safe ride.

Keep an Eye Out

- Actively supervise children until you're comfortable that they are responsible to ride on their own.
- Every child is different, but developmentally, it can be hard for kids to judge speed and distance of cars until age 10, so limit riding to sidewalks (although be careful for vehicles in driveways), parks or bike paths until age 10. No matter where you ride, teach your child to stay alert and watch for cars and trucks.
- Children should be able to demonstrate riding competence and knowledge of the rules of the road before cycling with traffic.

Model and Teach Good Behavior

- You'd be surprised how much kids learn from watching you, so it's extra important for parents to model proper behavior. Wear a helmet, even if you didn't when you were a kid.
- Teach your kids to make eye contact with drivers. Bikers should make sure drivers are paying attention and are going to stop before they cross the street.
- Tell your kids to ride on the right side of the road, with traffic, not against it. Stay as far to the right as possible. Use appropriate hand signals and respect traffic signals, stopping at all stop signs and stoplights.
- Stop and look left, right and left again before entering a street or crossing an intersection. Look back and yield to traffic coming from behind before turning left.

Be Bright, Use Lights

- When riding at dusk, dawn or in the evening, be bright and use lights – and make sure your bike has reflectors as well. It's also smart to wear clothes and accessories that have retro-reflective materials to improve biker visibility to motorists.
- Most states require a front light but allow the use of a rear reflector. Headlights aren't so much for bicyclists to see where they are going but for others to see them. Riding without a headlight means drivers won't see you, and surprising motorists is never a good idea.

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Fire Safety Tips

Everything you need to know to keep your kids safe around fire.

Home fires can start and spread quickly, which is why we all need to be careful and educated when it comes to fire safety. Just a little bit of planning can make a big difference for your family.

Check Your Smoke Alarms

- Working smoke alarms reduce the chances of dying in a fire by nearly 50 percent. They are a critical first step for staying safe, but in order to be effective, they have to be working properly.
- For the best protection, install smoke alarms on every level of your home, outside every sleeping area and in each bedroom.
- Use Daylight Savings Time as a reminder to check your smoke alarms. Replace conventional batteries at least once a year, even if alarms are wired directly into your home's electrical system.
- Consider installing a smoke alarm that has a 10-year battery.
- Smoke alarms expire after 10 years. So if your alarm is more than 10 years old, you should install a new one.

Every hour approximately 16 children are injured from fires or burns. Eighty-five of all fire-related deaths are due to home fires, which spread rapidly and can leave families as little as two minutes to escape once an alarm sounds.

Create and Practice a Fire Escape Plan

- Create and practice a home fire escape plan with two ways out of your house in case of a fire. Get a stopwatch and time how fast your family can escape. The kids will love it.
- As part of your plan, designate one person to get infants and small children out safely. Have a back-up plan for young children just in case the primary person is overcome by smoke.
- Smoke is toxic. Teach children to "get low and go" if there is smoke when they are leaving the home.
- Practice feeling the door, doorknob and cracks around the door with the back of your hand to see if they are too hot. Help your children practice this step.
- Choose a place to meet outside that is a safe distance away from your home.

In an Emergency, Leave Home Immediately

- In the event of a fire, grab your family and leave your home immediately. Once you're out of the house, stay out.
- Wait to call 911 until after you are out of the home.

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If You Live in an Apartment, Pull the Alarm

- If you don't hear the building's fire alarm, pull the nearest fire alarm "pull station" while leaving the floor.
- Know all of your building's fire escape exits and use the stairs to get out. Don't use the elevator.

If You're Stuck Inside, Cover the Areas Where Smoke Might Come In

- If you cannot safely escape your home or apartment, keep smoke out of the room by covering vents and cracks around the door, and call 911 or your fire department as quickly as possible.
- Then signal for help at the window with a light-colored cloth or a flashlight.

Keep Flammable Materials in Safe Areas

- Remember to keep space heaters at least three feet away from anything that can burn, and always closely supervise children and pets when the heater is turned on.
- Make sure you turn space heaters off when you leave the room.
- If using gasoline-powered devices, store gasoline in a locked location where children cannot access it. Keep only small quantities in an approved container that has child safety features.

Don't Over Plug

- To prevent possible fires, avoid plugging several appliance cords into the same electrical socket.

Stay Focused Around the Kitchen

- Use common sense in the kitchen. Limit distractions when cooking and don't leave a hot oven or stovetop unattended.
- Keep anything that can catch fire, such as dish towels or wooden spoons, away from your stovetop.
- Have a fire extinguisher in the kitchen in case of emergency, and make sure you know how it works. You might be surprised that most people don't know how to use one.

Install Barriers Such as Safety Gates Around Fireplaces, Ovens and Furnaces

- Make sure your fireplace is protected by a sturdy screen. Remember that glass screens can take a long time to cool down.
- If you are using a fireplace or wood stove, make sure you burn only seasoned hardwood such as oak, ash or maple.
- If small children live in or visit your home, use a safety gate around your fireplace or wood stove.

Blow Out Candles and Store Matches Out of Reach

- Keep candles at least 12 inches away from anything that can burn, and always blow them out when you leave the room or before you go to sleep.
- Make a habit of placing matches, gasoline and lighters in a safe place, out of children's reach. Avoid novelty lighters or lighters that look like toys.
- Teach kids to never play with matches, lighters or fireworks. Depending on the age and maturity level of your child, it may be reasonable to use the items with the supervision of an adult. Just be sure that a fire extinguisher and a phone are close by in case of an emergency.

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Gun Safety Tips

Everything you need to know about keeping kids safe around guns.

We need to take extra precautions when kids are in an environment where guns are present.

Store Guns and Ammunition Safely

- Store guns in a locked location, unloaded, out of the reach and sight of children.
- Store ammunition in a separate locked location, out of the reach and sight of children.
- Keep the keys and combinations hidden.
- When a gun is not in its lock box, keep it in your line of sight.
- Make sure all guns are equipped with effective, child-resistant gun locks.
- If a visitor has a gun in a backpack, briefcase, handbag or an unlocked car, provide them with a locked place to hold it while they are in your home.
- Leaving guns on a nightstand, table or other place where a child can gain access may lead to injuries and fatalities.

Talk to Your Kids and Their Caregivers

- Explain how a gun your kids might see on television or a video game is different from a gun in real life.
- Teach kids never to touch a gun and to immediately tell an adult if they see one.
- Talk to grandparents and the parents of friends your children visit about safe gun storage practices.

Dispose of Guns You Don't Need

- If you decide that you no longer need to have a gun in your home, dispose of it in a safe way. Consult with law enforcement in your community on how to do so.

It is estimated that about one third of households with children ages 17 and under have a gun in the home.

For more information visit safekids.org.

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Poisoning Prevention Tips

Everything you need to know to keep your kids safe from poisoning.

Let's face it, sometimes kids get into things that they probably shouldn't. Here are a few tips to keep little explorers from finding their way into household items that could be dangerous. But just in case, we'll also show you what to do if your child accidentally ingests something harmful.

Keep Cleaners and Other Toxic Products Out of Reach

- Store all household products out of children's sight and reach. Young kids are often eye-level with items under the kitchen and bathroom sinks. So any bleach, detergents, dishwasher liquid or cleaning solutions that are kept there should find a new storage location.
- Install child safety locks on cabinets where you have stored poisonous items. It only takes a few minutes, and it gives you one less thing to worry about.
- Read product labels to find out what can be hazardous to kids. Dangerous household items include makeup, personal care products, plants, pesticides, lead, art supplies, alcohol and carbon monoxide.
- Don't leave poisonous products unattended while in use. Many incidents happen when adults are distracted for a moment on the phone or at the door.
- Keep cleaning products in their original containers. Never put a potentially poisonous product in something other than its original container (such as a plastic soda bottle) where it could be mistaken for something else.
- Throw away old medicines and other potential poisons. Check your garage, basement and other storage areas for cleaning and work supplies you no longer need and can discard.

Check Your Purse for Potential Hazards

- Be aware of any medications or makeup that may be in your handbag. Store handbags out of the reach of young children.

Use Original, Child-Resistant Packaging

- Buy child-resistant packages when available.
- Keep products in their original packages to avoid confusion.

Half of the 2 million calls to poison control centers in 2011 were for exposures and ingestions among children ages 5 and under.

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Keep Medicines Up and Away

- Make sure that all medications, including vitamins, are stored out of reach and out of sight or children.
- Even if you are tempted to keep the medicine handy because you have to give another dose in a few hours, don't leave it on the counter between dosing. Always put medicines and vitamins away after every use.
- Learn more medication safety tips.

Check for Lead

- Check homes built before 1978 for lead-based paint. If lead hazards are identified, test your child for lead exposure and hire a professional to control and remove lead sources safely.
- Remove any peeling paint or chewable surfaces painted with lead-based paint.
- Regularly wash your child's toys and pacifiers to reduce the risk of your child coming into contact with lead or lead-contaminated dust.
- Check www.recalls.gov for more info on product recalls involving lead-based products. Follow the recommendations to eliminate any products such as toys or cookware that contain lead.

Have Poison Control on Speed Dial

- Program the toll-free number for the Poison Control Center **(800-222-1222)** into your home and cell phone and post it near your phone or on your refrigerator for the babysitter. Hopefully, you'll never need it, but it's nice to have just in case.
- Poison control centers offer fast, free, confidential help in English and Spanish. Most poisonings are resolved over the phone. The number works from anywhere in the United States 24 hours a day, seven days a week.
- If you suspect your child has been poisoned, call poison control. If your child has collapsed or is not breathing, call 911.
- Do not make the child vomit or give him anything unless directed by a professional.

Install a Carbon Monoxide Alarm and Identify Signs of Poisoning

- Install a carbon monoxide alarm on every level of your home, especially near sleeping areas, and keep them at least 15 feet away from fuel-burning appliances.

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Water Safety at Home

Everything you need to know to keep your kids safe in and around water at home.

Whether you're bathing your baby in the sink or splashing around with your toddler in the bathtub, water is great fun for kids. But it's also a place where safety must come first, so here are a few tips for kids who love to get wet.

Don't Leave Kids Alone in or Around Water

- Never leave your child unattended around water. We know it sounds strict, but there is no room for compromise on this one. Babies can drown in as little as one inch of water.
- Put the cell phone away, forget about all the other things you have to do and give young children 100 percent of your attention when they are near or around water.
- When using inflatable or portable pools, remember to empty them immediately after use. Store them upside down and out of children's reach. These types of pools can pose a drowning risk.

Remove Water From Tubs and Buckets After Use

- Once bath time is over, immediately drain the tub.
- Empty all tubs, buckets, containers and wading pools immediately after use. Store them upside down and out of children's reach.

Close Lids and Doors

- Keep toilet lids closed and use toilet seat locks to prevent drowning.
- Keep doors to bathrooms and laundry rooms closed.

Learn CPR

- Parents have a million things to do, but learning CPR should be on the top of the list. It will give you tremendous peace of mind – and the more peace of mind you have as a parent, the better.

Drowning is the leading cause of injury-related death among children between 1 and 4 years old. And it's the third leading cause of death among children.

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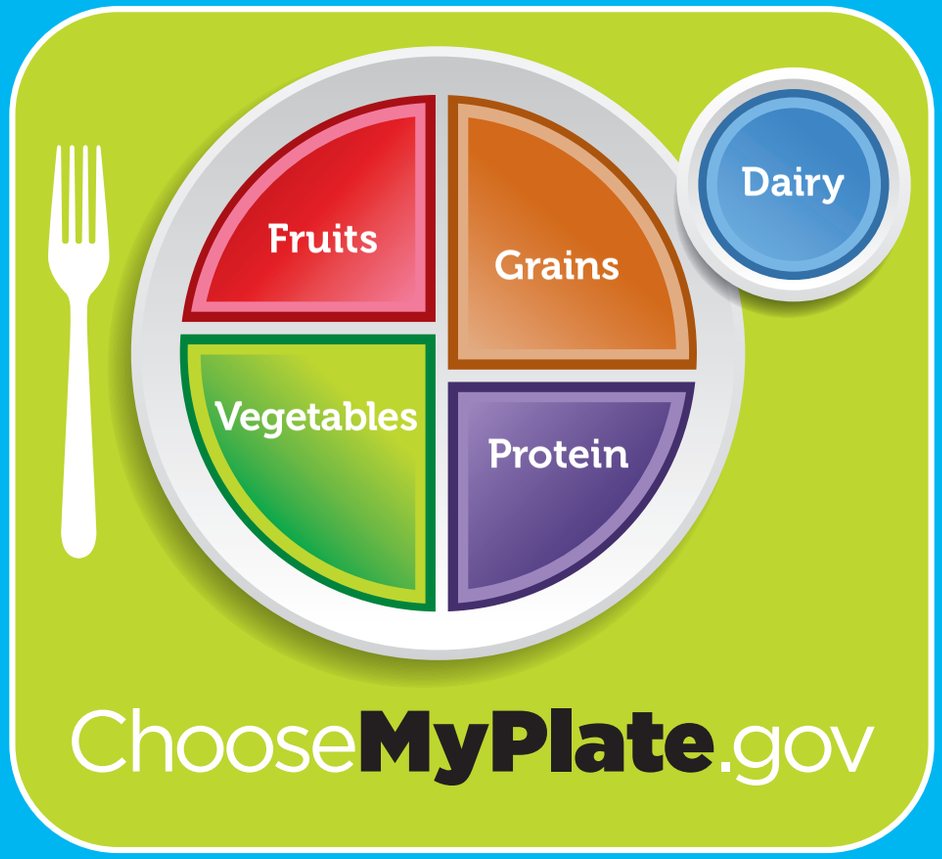
What's on your plate?



Before you eat, think about what and how much food goes on your plate or in your cup or bowl. Over the day, include foods from all food groups: vegetables, fruits, whole grains, low-fat dairy products, and lean protein foods.

Make half your plate fruits and vegetables.

Make at least half your grains whole.

Switch to skim or 1% milk.

Vary your protein food choices.

Vegetables	Fruits	Grains	Dairy	Protein Foods
Eat more red, orange, and dark-green veggies like tomatoes, sweet potatoes, and broccoli in main dishes. Add beans or peas to salads (kidney or chickpeas), soups (split peas or lentils), and side dishes (pinto or baked beans), or serve as a main dish. Fresh, frozen, and canned vegetables all count. Choose "reduced sodium" or "no-salt-added" canned veggies.	Use fruits as snacks, salads, and desserts. At breakfast, top your cereal with bananas or strawberries; add blueberries to pancakes. Buy fruits that are dried, frozen, and canned (in water or 100% juice), as well as fresh fruits. Select 100% fruit juice when choosing juices.	Substitute whole-grain choices for refined-grain breads, bagels, rolls, breakfast cereals, crackers, rice, and pasta. Check the ingredients list on product labels for the words "whole" or "whole grain" before the grain ingredient name. Choose products that name a whole grain first on the ingredients list.	Choose skim (fat-free) or 1% (low-fat) milk. They have the same amount of calcium and other essential nutrients as whole milk, but less fat and calories. Top fruit salads and baked potatoes with low-fat yogurt. If you are lactose intolerant, try lactose-free milk or fortified soymilk (soy beverage).	Eat a variety of foods from the protein food group each week, such as seafood, beans and peas, and nuts as well as lean meats, poultry, and eggs. Twice a week, make seafood the protein on your plate. Choose lean meats and ground beef that are at least 90% lean. Trim or drain fat from meat and remove skin from poultry to cut fat and calories.
For a 2,000-calorie daily food plan, you need the amounts below from each food group. To find amounts personalized for you, go to Choose**MyPlate**.gov.				
Eat 2½ cups every day **What counts as a cup?** 1 cup of raw or cooked vegetables or vegetable juice; 2 cups of leafy salad greens	**Eat 2 cups every day** **What counts as a cup?** 1 cup of raw or cooked fruit or 100% fruit juice; ½ cup dried fruit	**Eat 6 ounces every day** **What counts as an ounce?** 1 slice of bread; ½ cup of cooked rice, cereal, or pasta; 1 ounce of ready-to-eat cereal	**Get 3 cups every day** **What counts as a cup?** 1 cup of milk, yogurt, or fortified soymilk; 1½ ounces natural or 2 ounces processed cheese	**Eat 5½ ounces every day** **What counts as an ounce?** 1 ounce of lean meat, poultry, or fish; 1 egg; 1 Tbsp peanut butter; ½ ounce nuts or seeds; ¼ cup beans or peas

U.S. Department of Agriculture • Center for Nutrition Policy and Promotion
August 2011
CNPP-25
USDA is an equal opportunity provider and employer.

Cut back on sodium and empty calories from solid fats and added sugars

Look out for salt (sodium) in foods you buy. Compare sodium in foods and choose those with a lower number.

Drink water instead of sugary drinks. Eat sugary desserts less often.

Make foods that are high in solid fats—such as cakes, cookies, ice cream, pizza, cheese, sausages, and hot dogs—occasional choices, not every day foods.

Limit empty calories to less than 260 per day, based on a 2,000 calorie diet.

Be physically active your way

Pick activities you like and do each for at least 10 minutes at a time. Every bit adds up, and health benefits increase as you spend more time being active.

Children and adolescents: get 60 minutes or more a day.

Adults: get 2 hours and 30 minutes or more a week of activity that requires moderate effort, such as brisk walking.

Division of Tuberculosis Elimination Educational and Training Materials

Note: All materials listed are in the public domain. You may reproduce these materials without permission. You are also free to adapt and revise these materials; however, you must remove the CDC name and logo if changes are made. Please indicate desired quantity in the blank provided. All materials are free of charge unless otherwise noted.

For Health Care Providers

World TB Day Posters
http://www.cdc.gov/tb/events/WorldTBDay/poster.htm

Stop TB In My Lifetime ***(2013)*** ***(Order Limit 20 Each)***
____ (22-1498) **English** *(Available Online Only)*
____ (22-1499) **Spanish**

Stop TB In My Lifetime **(2012)**
English *(Available Online Only)*
Spanish *(Available Online Only)*

TB Elimination: Together We Can! **(2011)**
____ (22-0606) **English**
Spanish *(Available Online Only)*

TB Elimination: Together We Can! **(2010)**
____ (21-1043) **English** *(Available Online Only)*
Spanish *(Available Online Only)*

Partnerships for TB Elimination **(2008)**
English *(Available Online Only)*
Spanish *(Available Online Only)*

TB Elimination: Now Is the Time
English (2004) – Olive Background *(Available Online Only)*
Spanish (2004) – Olive Background *(Available Online Only)*
English (2004) – Green Center, Top and Bottom has Blocks with Faces *(Available Online Only)*
English (2003) – Blue Background *(Available Online Only)*
Spanish (2003) – Blue Background *(Available Online Only)*
English (2003) – Orange Background *(Available Online Only)*
Spanish (2003) – Orange Background *(Available Online Only)*

Forging Partnerships to Eliminate Tuberculosis Toolkit
A resource guide and toolkit for strengthening TB elimination strategies through partnerships. The booklet is a printed version of the guide and toolkit. The CD ROM includes the guide (in PDF format) and toolkit (in PDF and Word formats that can be adapted for local use). The CD ROM can also be ordered separately.
____ (00-6552) **Guide and CD ROM (2011)** ***(Order Limit 10)*** *(Currently Out of Stock)*

TB Elimination - Now Is the Time Brochure (2012) ***(Order Limit 100)*** *(Currently Out of Stock)*
____ (99-6893) *A six-page color brochure designed to educate the general public about the status of the TB epidemic in the U.S. with general TB information, HIV-TB co-infection, TB's disproportionate burden on minorities and what needs to be done to eliminate TB in the US*

Effective TB Interviewing for Contact Investigation ***(Order Limit 5 Each)***
____ (99-8214) **Facilitator-led Training Guide (2006)** - *An interactive, skill-building guide designed to improve the knowledge and proficiency of TB staff responsible for conducting the TB interview. Guide is intended for facilitators who will be conducting TB interviewing courses.* *(Currently Out of Stock)*
____ (99-8215) **Self-Study Modules (2006)** - *A series of 4 modules, including an overview of the TB interview for contact investigations, basics of communication and patient education, cultural competency, and special interview circumstances.*
____(22-0660) **DVD (2011)**
67-minute video/DVD demonstrates successful interviewing strategies with TB patients and is designed to enhance the knowledge and skills of health care workers who are responsible for conducting TB interviews with patients as part of contact investigations. *(Currently Out of Stock)*

Understanding the TB Cohort Review Process ***(Order Limit 50 Each)***
Explains the three key elements of the cohort review process and how to adapt the cohort review process to your own TB program.
____ (99-8369) **Guide and DVD (2006)** *(Currently Out of Stock)*
____ (99-9271) **DVD (2006)**

Latent Tuberculosis Infection: A Guide for Primary Health Care Providers (2013) ***(Order Limit 25)***
____ (22-0468) *Booklet on latent TB infection diagnosis and treatment.*

TB/HIV Co-infection Brochure (2005) ***(Order Limit 100)*** *(Currently Out of Stock)*
____ (99-7314) *4-page color brochure is designed to educate staff of AIDS service organizations about TB and encourage them to collaborate with their local TB control program.*

Reported TB in the United States (2010) *(Available Online Only)*
Statistics on tuberculosis cases and case rates reported for 2010.
http://www.cdc.gov/tb/statistics/reports/2010/pdf/report2010.pdf
Reported TB in the United States (2011) *(Available Online Only)*
Statistics on tuberculosis cases and case rates reported for 2011.
http://www.cdc.gov/tb/statistics/reports/2011/pdf/report2011.pdf
Reported TB in the United States (2012) *(Available Online Only)*
Statistics on tuberculosis cases and case rates reported for 2012.
http://www.cdc.gov/tb/statistics/reports/2012/pdf/report2012.pdf

Core Curriculum on Tuberculosis ***(Order Limit 25)*** *(Currently Out of Stock)*
____ (21-1092) **Guide – 6th Edition (2013)**
The Core Curriculum is intended for use as a self-study guide or reference manual for clinicians and other public health professionals caring for people with or at high risk for TB disease or infection. In addition, the Core Curriculum includes a slide set designed to be useful in developing educational programs.
The Core Curriculum was revised in 2011 to reflect new guidelines for TB prevention, treatment, testing, diagnosis, and patient management and public health practice.

Mantoux Tuberculin Skin Testing ***(Order Limit 10 Each)***
____ (99-7047) **Ruler (2002)** *(Ruler to use in measuring test reaction)*
____ (00-5564) **Wall Chart (2004)** *(Wall chart of steps and procedures in skin testing)*
____ (99-9760) **DVD Kit (2003)** *(Includes DVD, facilitator guide, and ruler)*

Self-Study Modules on Tuberculosis ***(Order Limit 10 Each)***
____ (00-6514) **Modules 1-5 (2008) –** *An updated series of five modules covering epidemiology, transmission and pathogenesis, diagnosis, treatment of TB infection and TB disease, and infection control.*
(Currently Out of Stock)
Modules 6-9 (2000) – *A continuation of the Self-Study Modules on TB series, these four modules cover contact investigations, confidentiality, TB surveillance and case management in hospitals and institutions and patient adherence.* *(Available Online Only)* *http://www.cdc.gov/tb/education/ssmodules/default.htm*

Think TB! ***(Order Limit 20 Each)***
Poster listing the symptoms of tuberculosis
____ (00-6186) **English (2011)**
____ (00-6406) **Spanish (1993)**

TB Education and Training Resources Web Site
This Web site includes a searchable database of materials from numerous national and international organizations. It can be found at ***www.findtbresources.org.***

For Patients and the General Public

Questions and Answers about TB ***(Order Limit 50 Each)***
Booklet on TB transmission, skin test, and treatment, including DOT and medication side effects
____ (21-1024) **English (2009)**
____ (21-1019) **Spanish (2009)** *(Currently Out of Stock)*

PATIENT EDUCATION MATERIALS SERIES:
Get the Facts About TB Disease ***(Order Limit 50 Each)***
Booklet about TB transmission, treatment for TB disease, and how to communicate with family and friends about TB
____ (99-8218) **English (2005)** *(Currently Out of Stock)*
____ (99-9369) **Spanish/English (2008)** *(Currently Out of Stock)*
____ (99-9365) **Tagalog/English (2008)**
What You Need to Know About TB Infection ***(Order Limit 50 Each)***
Booklet on TB infection, including the TB skin test, treatment, and adherence to medication
____ (99-8219) **English (2005)**
____ (99-9373) **Spanish/English (2008)** *(Currently Out of Stock)*
____ (99-9366) **Tagalog/English (2008)**
What You Need to Know About the TB Skin Test ***(Order Limit 50 Each)***
Fact sheet on the basics of the TB skin test
____ (99-8220) **English (2005)** *(Currently Out of Stock)*
____ (99-9368) **Spanish/English (2008)** *(Currently Out of Stock)*
____ (99-9367) **Tagalog/English (2008)**
Protect Your Family and Friends from TB: The TB Contact Investigation ***(Order Limit 50 Each)***
Booklet on how to protect family and friends from TB, and how to talk to a healthcare worker during a contact investigation
____ (99-8221) **English (2005)**
____ (99-9370) **Spanish/English (2008)**
____ (99-9362) **Tagalog/English (2008)**
Take Steps to Control TB When You have HIV ***(Order Limit 50 Each)***
Booklet about the importance of TB testing, treating TB infection, and treating TB disease when a person has HIV infection
____ (99-8222) **English (2005)** *(Currently Out of Stock)*
____ (99-9372) **Spanish/English (2008)**
____ (99-9360) **Tagalog/English (2008)**
Staying on Track with TB Medicine ***(Order Limit 50 Each)***
Booklet about treatment and ways to adhere to medication regimens for TB infection and TB disease
____ (99-8223) **English (2005)**
____ (99-9371) **Spanish/English (2008)**
____ (99-9363) **Tagalog/English (2008)**

OTHER MATERIALS FOR PATIENTS AND GENERAL PUBLIC:
Tuberculosis - Get the Facts! ***(Order Limit 100 Each)***
One-page pamphlet on basic facts about TB transmission, infection, and the tuberculin test
____ (00-5743) **English (2005)**
____ (00-5772) **Spanish (2006)**

Tuberculosis - The Connection Between TB and HIV (the AIDS Virus) ***(Order Limit 100 Each)***
One-page pamphlet on the risk of HIV-related TB, tuberculin testing, and preventive therapy
____ (00-5738) **English (2005)**
____ (00-5745) **Spanish (2006)**

Stop TB Poster - *Describes how TB is spread and the difference between latent TB infection and TB disease*
____ (00-6474) *Poster* ***(Order Limit 25)***

Stop TB Fact Sheet: *http://www.cdc.gov/tb/publications/Posters/images/StopTBsmall.pdf*
Single sheet (8 ½ x 11") duplicating the Stop TB Poster

Stop TB Poster – Spanish - *Describes how TB is spread and the difference between latent TB infection and TB disease*
____ (22-1577) *Poster available online* ***(Order Limit 25)***
http://www.cdc.gov/tb/esp/publications/Posters/images/TBposter_sp_18x24_hi.pdf

Stop TB Fact Sheet Spanish: *http://www.cdc.gov/tb/esp/publications/Posters/images/TB_sp_8.5x11_hi.pdf*
Single sheet (8 ½ x 11") duplicating the Stop TB Poster – Spanish

Major Guidelines – additional TB guidelines may be found on the DTBE website at **http://www.cdc.gov/tb/publications/guidelines/default.htm**

CDC. Recommendations for Use of an Isoniazid-Rifapentine Regimen with Direct Observation to Treat Latent *Mycobacterium tuberculosis* Infection. *MMWR* 2011;60:1650-1653.
(Available Online Only)

____ (22-0089) **Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection – United States, 2010.** *MMWR June 25,2010.* ***(Order Limit 50)***

Plan to Combat Extensively Drug-Resistant TB *MMWR, 02/13/09.*
(Available Online Only)

Prevention and Control of TB in Correctional and Detention Facilities. *MMWR, 7/6/2006.*
(Available Online Only)

Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.
MMWR, 12/28/05. *(Available Online Only)*

____ (99-8451) **Guidelines for the Investigation of Contacts of Person with Infectious TB: Recommendations of NTCA and CDC; and Guidelines for Using the QuantiFERON TB Gold Test for Detecting *Mycobacterium tuberculosis.*** *MMWR, 12/16/05.* ***(Order Limit 50)***
http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf

____ (99-8160) **National Plan for Reliable Tuberculosis Laboratory Services Using a Systems Approach.**
MMWR, 4/15/2005 ***(Order Limit 50)***

Treatment of Tuberculosis. *MMWR, 6/20/03.* *(Available Online Only)*

Update: Adverse Event Data and Revised American Thoracic Society/CDC Recommendations Against the Use of Rifampin and Pyrazinamide for Treatment of Latent TB Infection. *MMWR*, 2003.
(Available Online Only)

Preventing and Controlling Tuberculosis Along the U.S.-Mexico Border. *MMWR*, 1/19/01.
(Available Online Only)

Diagnostic Standards and Classification of Tuberculosis in Adults and Children.
Reprint from the *American Journal of Respiratory and Critical Care Medicine*, 4/00.
(Available Online Only)

Ordering Information

To order materials online, please use the online publication ordering system at http://wwwn.cdc.gov/pubs/tb.aspx.
You may also mail this form to: Communications, Education, and Behavioral Studies Branch, DTBE, NCHHSTP, CDC, 1600 Clifton Road, NE, Mailstop E-10, Atlanta, GA 30333.

PLEASE NOTE: Large shipments are sent by UPS and require a street address. Large packages cannot be shipped to PO Boxes. International orders are limited to 10 copies of each publication.

Date: _____

Name: _____ Phone: ( ) _____

Address: _____

_____

Additional Materials Available Online from the Division of TB Elimination

Fact Sheets

The following fact sheets are available at http://www.cdc.gov/tb/publications/factsheets/default.htm:

General Information

- Tuberculosis - General Information
- BCG Vaccine
- The Difference Between Latent TB Infection and TB Disease
- TB Fact Sheets
  - TB Can Be Treated
  - Exposure to TB
  - TB and HIV/AIDS
  - You Can Prevent TB
  - Testing for TB

Drug-Resistant Tuberculosis

- Multidrug-Resistant TB
- Extensively Drug-Resistant Tuberculosis (XDR TB)
- CDC's Role in Preventing Extensively Drug-Resistant TB

Testing and Diagnosis

- Testing for Tuberculosis
- Recommendations for HIV Screening in TB Clinics
- Interferon-Gamma Release Assays (IGRAs)-Blood Tests for TB Infection
- Tuberculin Skin Testing
- Diagnosis of Tuberculosis Disease
- Targeted Tuberculin Testing and Interpreting Tuberculin Skin Test Results

Treatment

- Treatment of Latent Tuberculosis Infection: Maximizing Adherence
- Treatment Options for Latent Tuberculosis Infection
- Treatment of Drug-Resistant Tuberculosis
- Treatment of Drug-Susceptible Tuberculosis Disease in Persons Not Infected with HIV
- Treatment of Drug-Susceptible Tuberculosis Disease in HIV-Infected Persons

Data and Statistics

- A Global Perspective on TB
- Trends in Tuberculosis, 2008, United States
- The Revised Report of Verified Case of TB
- The National TB Indicators Project (NTIP)
- The National TB Indicators Project (NTIP): Frequently Asked Questions
- TB Genotyping Information Management System (TB-GIMS) (2008)
- TB Genotyping

Infection Control

- Respiratory Protection in Health-Care Settings
- Infection Control in Health-Care Settings

Fact Sheets (cont'd)

Special Populations

- TB Information for Employers in Non-health-care Settings
- TB in Blacks
- TB in Minorities
- Tuberculosis Information for International Travelers
- Tuberculosis and Pregnancy

Slide Sets

The following slide sets are available at http://www.cdc.gov/tb/publications/slidesets/default.htm:

- Core Curriculum on Tuberculosis
- Epidemiology of Pediatric Tuberculosis in the United States
- Guidelines for Preventing the Transmission of *M. tuberculosis* in Health-Care Settings
- Investigation of Contacts of Persons with Infectious Tuberculosis
- Prevention and Control of Tuberculosis in Correctional and Detention Facilities
- Tuberculosis in the United States – 2010 (Data and Statistics)
- Targeted Tuberculosis (TB) Testing and Treatment of Latent Tuberculosis Infection
- Treatment of Tuberculosis
- Surveillance

Maryland Department of Health and Mental Hygiene
Center for Immunization
Health Education Materials Order Form

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone:_____ Fax: _____ Order Date _____

To order: fax this form to 410-799-1370 or call 410-799-1940

Please print clearly. All orders shipped via UPS ground. Please allow 1 week for delivery.

Item	Item	Order Limit	Quantity
F100	Immunization Record (Black Book)	—	
F101	Adult Immunization Cards	—	
F102	DHMH Form 896 - Immunization Certificate	—	
F103	Maryland Recommended Childhood & Adolescent Immunization Schedule	3	
F105	Vaccine Administration Record (VIS Dated)	200	

	Vaccine Information Statements		
V100	☐ English Camera Ready Set	***1 camera-ready set***	
Additional languages are available at: **www.immunize.org/vis**			

HIV/AIDS PREVENTION MATERIALS ORDER FORM

Organization:

Contact: **Date:**

Address:

City: **State:** **Zip:**

Telephone No.: **Fax No.**

Condom Registration Number:

What Event, (if any), will these materials be used for?

Note: Order may be placed by phone (410) 799-1940 or faxed to (410) 799-1370.

There is a limit of 100 brochures total per week or 400 total per month.

Item	Description	Qty Ordered
04000	Sample Kit **(Brochures Only-Limit 1 per order)**	
1000	5 Smart Steps to Condoms	
NEW 1001	5 Smart Steps to Condoms **(SP)**	
1002	5 Smart Steps to Good Sex	
1004	5 Smart Steps to Stop HIV	
1006	50 Things You Should Know **(Eng)**	
1010	101 Reasons to Be Monogamous	
1012	101 Ways to Get High	
1014	101 Ways to Make Love **(Eng)**	
1015	101 Ways to Make Love **(Sp)**	
1016	101 Ways to Say No to Sex **(Eng)**	
1017	101 Ways to Say No to Sex **(Sp)**	
1023	HIV and Men- **A Call to Men of Color**	
1024	A Call to Women of Color-**Women & HIV**	
1025	A Guy Thing	
1028	A Teen's Guide to HIV & AIDS	
1030	About Addiction	
1035	About Caring for People with AIDS	
1040	About HIV & Shooting Drugs	
1055	About Standard Precautions	
1060	About Staying Out of Prison	
1065	About STD's **(Eng)**	
1066	About STD's **(Sp)**	
1070	About Women, HIV & AIDS	
1070.1	Abstinence-Saying No To Sex	
1091	AIDS & My Sister	
1100	AIDS: Ending an Epidemic	
1105	HIV & AIDS-Learn the Facts **(Sp)**	
1110	HIV & AIDS-Learn the Facts **(Eng)**	
1125	Peer Pressure & Choices	
1130	All Inmates Deserve Respect **(Eng)**	
1131	All Inmates Deserve Respect **(Sp)**	
1133	Anyone Can Get AIDS **(Sp)**	
1200	Be Cool	
1210	Better Sex	
1215	Beyond Fear **(Eng)**	
1216	Beyond Fear **(Sp)**	
1315	Condom Self-Test	
1320	Condoms: What Women Need to Know **(Eng)**	

Item	Description	Qty Ordered
1321	Condoms: Women Need to Know **(Sp)**	
1335	Christina's Story About HIV **(Eng)**	
1336	Christina's Story About HIV **(Sp)**	
1355	Drug Facts	
1372	Female Condom Instructions-Leaflet	NEW
1374	Female Condom Instructions **(E/S)**	
1380	Get Informed not Infected **(Eng)**	
1400	Giving Your Child-Facts **(Eng)**	
1401	Giving Your Child-facts **(Sp)**	
1425	Hepatitis A **(Eng)**	
1425.1	Hepatitis A **(Sp)**	
1426	About Hepatitis B **(Eng)**	
1426.1	About Hepatitis B **(Sp)**	
1427	Hepatitis C-What You Should K **(Eng)**	
1427.1	Hepatitis C-What You Should K **(Sp)**	
1429	HIV, AIDS & Shooting Up	
1430	HIV/AIDS Info for Inmates **(Eng)**	
1431	HIV/AIDS Info for Inmates **(Sp)**	
1432	HIV & AIDS Basics **(Eng)**	
1440	HIV/ AIDS Prev (Hot & Safe)	
1443	HIV/ AIDS: A Reality Check	
1447	HIV & Sex: Unsafe/ Safer/ Safest	
1448	HIV & Other STD's-Double Threat	
1450	HIV Facts **(Eng)**	
1451	HIV Facts **(Sp)**	
1452	HIV & AIDS-Facts for Young People	
1460	HIV Negative HIV/ Neg	
1469	HIV/ STD Testing (for You)	
1470	HIV-To Protect Yourself **(Eng)**	
1471	HIV-To Protect Yourself **(Sp)**	
1475	How To Use A Condom **(E/S)-50 pk.**	
1480	It's Negative-So Now What?	
1500	Information Phone Card-**100 pk.**	
1525	Keep Free From HIV-**For Men (Afr.)**	NEW
1549	Learning About HIV/AIDS-Wkbook	
1552	Know What? We Kn HIV-Wkbook	
1553	Know What? We Kn HIV-Leader's G	
1554	Lesbians & HIV	

HIV/AIDS PREVENTION MATERIALS ORDER FORM

Organization:		
Contact:		**Date:**
Address:		
City:	**State:**	**Zip:**
Telephone No.:	**Fax No.**	
Condom Registration Number:		
What Event, (if any), will these materials be used for?		

Note: Order may be placed by phone (410) 799-1940 or faxed to (410) 799-1370.

There is a limit of 100 brochures total per week or 400 total per month.

Item	*Description*	*Qty Ordered*
1555	Living With HIV (DIN)	
1560	Living With HIV (**Eng**)	
1561	Living With HIV (**Sp**)	
1561.1	Living Well w HIV **Handbook** (**Eng**)	
1600	Making Decisions About Sex	
1605	Making Resp. Choices Abt. Sex	
1615	My Brother Got AIDS	
1620	My Family Never Talked (**Eng**)	
1621	My Family Never Talked (**Sp**)	
1622	On Beating HIV Teen- Wkbook	
1623	On Beating HIV Teen-Leader's Guide	
1624	One Test May Save Your Babies Life (**Eng**)	
1625	One Test May Save Your Babies Life (**Sp**)	
1640	Out & Proud-Preventing HIV-Gay/Bisexual M	
1640.1	Overcoming Depression-HIV :Pos. Choices	
1655	Positive Living	
1780	Protect The Love	
1790	Protect The Blood	
1795	Protégé a Los Tuyos	
1800	Safer Sex	
1803	Safer Sex Self-Test	
1804	Safer Sex Self-Exam (**Sp**)	
1805	Saying "no" to Sex (**Eng**)	
NEW 1806	Saying "no" to Sex (**Sp**)	
1810	Sex and You	
1812	Sex Is Safer With A Condom (**Eng**)	
1813	Sex Is Safer With A Condom (**Sp**)	
1815	Sex Talk	
1822	Stop Wondering-Get Tested- HIV/Other STDs	
1825	STD Blues	
1830	STD Facts	
1832	STD Facts/HIV Connection (**Sp**)	
1855	Talking About HIV Status (For You)	
1860	Talking With Your Child Abt. AIDS	
1865	Talking With Your Partner (**Eng**)	
1866	Talking With Your Partner (**Sp**)	
1869	Teens & Abstinence-Relationships	
1870	Teen Sex? It's OK to Say No	

Item	*Description*	*Qty Ordered*
1875	Teens Talk About HIV & AIDS	
1880	Ten Good Reasons to Use A Condom	
1910	VD? STD? Who, Me?	
1915	What People Over 50 Shd Know	
1920	What Everyone Should Kn (**Sp**)	
1925	What Everyone Should Kn (**Eng**)	
1926	Who Knew? The HIV Facts- Wkbook	
1927	Who Knew? The HIV Facts-Leaders G	
1930	What People of Faith Should Know	
1931	What's Up HIV & AIDS Wkbook	
1932	What's Up HIV & AIDS- Leaders Gd.	**OUT**
1940	When A Loved One Has AIDS (**Eng**)	
1941	When A Loved One Has AIDS (**Sp**)	
1945	Women & HIV-Using a Condom	
1950	Women, HIV & AIDS, Facts-Life	
1960	Worried About HIV/ Get Tested (**Sp**)	
1980	You, Your Baby & HIV (**Eng**)	
1981	You, Your Baby & HIV (**Sp**)	
1982	Your Partner Is HIV+, what now?	
1984	Young & Gay: Protect from HIV	
1985	Young People Get HIV	
1986	Young People Get HIV (**Sp**)	
2000.1	Star Track Card-Boy, ea.	
2002.1	Star Track Card-(**Sp**) ea.	
2003.1	Star Track **Flyer**- Boy, ea	
2005.1	Star Track **Flyer**-Doin' It- (**Sp**)	
2100.1	"Hitting The Skins" Card, ea.	
2101.1	"Hitting The Skins", Flyer, ea.	

See Page Three of Order Form for Restricted Materials, Condoms, Dental Dams and Wet Lubricant

HIV/AIDS PREVENTION MATERIALS ORDER FORM

Organization:		
Contact:		**Date:**
Address:		
City:	**State:**	**Zip:**
Telephone No.:	**Fax No.**	
Condom Registration Number:		
What Event, (if any), will these materials be used for?		

Note: Order may be placed by phone (410) 799-1940 or faxed to (410) 799-1370.

Restricted Materials

The following brochures are Restricted. These brochures contain explicit materials not intended for everyone. To Order these materials you must be pre-approved. To obtain approval call Tonya Williamson @ 410-767-5061. Approval is kept on Record.

3010	Safer Sex Can Be Fun	
3015	HIV Facts: for Men ONLY	
3020	HIV: Positive Choices (Living Poz)`	
3049	A Christians Response to AIDS	
3105	Calling All Girls-Booklet	
3400	Keep It Up (**E/S**)	
3401	Keep It Up (**Eng**)	
3500	Safer Sex Condom Guide	
3510	Stopping Stereotypes	
3551	Dick & Jane (**Poster**)	
4033	Wear Your Rubbers (Limit of 5 per order)	
4034	It Looks Bigger With A Condom- limit 5	

Infectious Disease and Environmental Health Administration Educational Material Distribution Center at State Use Industries

Condoms, Dental Dams and Wet Lubricant

Item	*Description*	*Qty Ordered*
7033	Durex w/o N9 Enhanced Pleasure (1,000 per case)	
7010	5100's Mint (1,000 per case)	
7016	5300's Multi-colored (1,000 per case)	
7020	5700's Non-Lubricated (1,000 per case)	
7000	5800's Lubricated w/o N9 (1,000 per case)	
7035	6200's Tuxedo (1,000 per case)	
7050	6800's Assorted Flavored, Ansell (1,000 per case)	
7055	Durex Maximum Love Lubricated XL(100 per case)	
7026	Polyurethane, Non-Latex (72 per case)	
7100	Female Condoms (100/bag=case)	
7252	Dental Dams (10 x 6/ 120 to a case)	
5000	Wet Lubricant (Limit of 100 per month)	

Educational Materials – Order Form

Materials are wrapped in quantities of 25 forms per pack, unless otherwise noted. Most material requests for less than 25 quantities per handout will be E-mailed to the contact.

**** Note: For orders quantities 100 + please allow 4-6 weeks for processing and shipping****

Item	English Qty.	Spanish Qty.	Total Qty.
Maryland's Child Passenger Safety Law card		N/A	
Maryland's CPS Law (2-sided Flier)			
AAP RF to Two/Why Keep Kids RF (2-sided flier)		N/A	
SRN: Check Your Child's Car Seat			
SRN: This is the Way the Baby Rides			
SRN: Car Safety for Growing Babies			
SRN: Meeting the Toddler Car Seat Challenge			
SRN: Boosters are for Big Kids			
SRN: Buckling Up, Keeping Youth Safe			
SRN: Grandparent's Guide to Car Seats			
SRN: Car Seat Safety for Tiny Babies (low birth weight infants)			
Every Child Deserves a Safe Ride Brochure (2-sided- English/Spanish)			
"Prescription" Pad (Tear-off Sheets/100 per pad)		N/A	
MD KISS Poster		N/A	
MD KISS Brochure		N/A	
Other: _____			

Please print legibly

Name: _____

Agency: _____

Address: _____

Phone/Fax: _____

Email: _____

Please return this form via fax or mail:
MD Kids In Safety Seats
201 W. Preston St
Baltimore, MD 21201
Phone: 800-370-SEAT (7328)
Fax: 410-333-5030

FOR OFFICE USE ONLY

Date Mailed/Presented/Emailed:

By:

Rev 11/13

MARYLAND DEPARTMENT OF THE ENVIRONMENT
Lead Poisoning Prevention Program • Lead Surveillance & Registration Division
1800 Washington Boulevard • Suite 630 • Baltimore Maryland 21230
410-537-3847 • 1-800-633-6101 • www.mde.state.md.us

Educational Materials
Lead Poisoning Prevention Program

Organization:_____
Contact:_____
Date:_____
Address:_____
City: _____ **State:** _____ **Zip code:** _____
Telephone No.: _____ **Fax No:** _____
E-Mail Address:_____

Note: Orders may be placed by phone (410) 799-1940 or fax (410) 799-1370

Brochures:

_____ Keep Your Home Lead Safe (English)
_____ Food and Good Nutrition
_____ Chips, Flakes, Peels, Dust
_____ Arabic _____Burmese _____English _____Farsi (Persian)
_____French _____Russian _____Somali _____Spanish _____Swahili

Educational Materials Required Under the MD Reduction of Lead Risk in Housing Law

_____ Notice of Tenant's Rights (includes Notice of Defect) (English)
_____ Notice of Tenant's Rights (includes Notice of Defect) (Spanish)
_____ EPA Booklet: "Protect Your Family From Lead in your Home" (English)
Call 1-800-424-LEAD (5323) to order

Promotional Items:

_____ Year Round Posters (19 1/2" x 24")
_____ Year Round Mini-Posters (8" x 11")
_____ Stickers – "We Want to be Lead Safe"

Fact Sheets about the Maryland Reduction of Lead Risk in Housing Law:

___ Summary of Owner Rights and Responsibilities
___ "Standard of Care" What Owners Need to Do to Comply
___ Lead Paint Certificates for Rental Housing
___ Meeting Risk Reduction Standards
___ Educational Materials Requirements Under the MD Lead Law
___ Lead-Free "Opt – In" Units Responsibilities Under the MD Lead Law
____ DHCD Grant and Loan & Rehabilitation Sheets
___ DHCD Housing Rehabilitation Programs