



NUNAVUT WELL-BABY RECORD

EVIDENCE-BASED INFANT/CHILD HEALTH

MAINTENANCE GUIDE:

4 – 5 YEARS OLD

Surname		Given Name	
Date of Birth <i>DD MM YYYY</i>	<input type="checkbox"/> M <input type="checkbox"/> F	Child HCP#:	
Information Source (and relation)			
Contact Name (if different)		Contact Phone Number:	
Birth Mother HCP#		Home Community/Health Centre	

PAST PROBLEMS / RISK FACTORS / FAMILY HISTORY: Age at Visit
____ yrs ____ mths

TB Exposure

Current Family: Birth family Adopted Foster care
 Guardian care changed since previous visit (2-3 years old)
 Foster/Adopted Parents: _____

PARENT / GUARDIAN CONCERNS:

Height (cm)	Weight (g)	HC (cm)
%	%	%

NUTRITION (SINCE 2-3 YEARS OLD)

How often does your child eat or drink:
 Country Food (trad. meat, berries, etc.):
 Never < Once/week ≥ Once/week Daily or more
 Sweetened drinks (crystals, pop, etc.):
 Never < Once/week ≥ Once/week Daily or more

Since your child was 2-3 years old:
 Were there times when the food for you and your family just did not last and there was no money to buy enough food?
 Never Sometimes Often Don't know/Refused
 Has your baby attended an early childhood care program? No Yes (specify): _____

Vitamin D Supplementation:
 Do you have Vit. D drops at home? No Yes
 If Yes: Are they given to your child?
 Never Sometimes Daily → Amt given: _____ IU
Rickets Diagnosis: No Yes Unknown

DENTAL

Teeth brushing frequency: < Daily Daily > Daily
 Tooth extractions: No Yes

Oral assessment: Healthy Unhealthy
Tooth decay (including white spots): No Yes

ENVIRONMENT

Maternal Smoking: No Yes → Amount (cig/day): _____
 Location of smoking: Inside Outside
 # People smoking inside the house: _____
 # People in house: _____ # Bedrooms in house: _____

Substance use in household: No Yes Don't Know/Refused
 Do you have any concerns regarding your child's safety? No Yes
Nurse suspects abuse: No Yes Unsure
Social services involved: No Yes Unknown

PHYSICAL EXAMINATION / MEDICAL HISTORY (SINCE 2-3 YEARS OLD)

	N	A
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (red reflex)/Visual acuity	<input type="checkbox"/>	<input type="checkbox"/>
Corneal light reflex	<input type="checkbox"/>	<input type="checkbox"/>
Cover-uncover test & inquiry	<input type="checkbox"/>	<input type="checkbox"/>
Hearing inquiry	<input type="checkbox"/>	<input type="checkbox"/>
Tonsil size / Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>

N = Normal
A = Abnormal

Developmental Assessment: Parental concern about delay: No Yes
 Tool used: _____
 General development delay 'Impression' None Mild Moderate Severe
 Speech/language delay 'Impression' None Mild Moderate Severe
 Referred for support: P.T. O.T. Speech Other
Diagnosed developmental condition: _____
SINCE 2-3 YEARS OLD: Had injury serious enough to seek medical attention: No Yes
 If yes: Head injuries: No Yes → Injury severity: Mild Severe
 Fractures: No Yes
 Dental: No Yes Burns: No Yes

SINCE 2-3 YEARS OLD: Birth Defect Reporting Form completed

Birth Defects detected: _____

Ear tube insertion: No Yes Chronic draining ears: No Yes
 # times Antibiotics taken for ear infections: _____
 Reactive airway / Asthma: No Yes → If Yes: Age at onset: _____
Seizures: No Yes → If Yes: Meds required No Yes
 w/ Fever No Yes Unknown
 w/ Low blood sugar No Yes Unknown

Lung Infections: # Admissions: _____
 Admission to: _____ Type(s): _____
 Health centre Pneumonia
 Regional hospital Bronchiolitis
 Tertiary centre TB
 ICU Unknown Other

ANEMIA SCREENING

Hgb (fingerprick): _____
 If needed, do venipunc
 Hgb (venipunc): Done Not done

Lab Results: (if venipunc - fill in later)
 Hgb _____
 MCV _____ Ferritin _____ CRP _____

SINCE 2-3 YEARS OLD:
 Iron prescribed: No Yes
 Iron taken: No Yes Sometimes

ASSESSMENT
 Include notes on abnormal findings

Well infant Needs follow-up Needs referral

SIGNATURE: _____

DATE: *DD MM YYYY*

VACCINES UP-TO-DATE: No Yes Unknown (follow Nunavut Immunization Guide)

<p>EDUCATION AND ADVICE</p> <p>(similar topics for 18mth, 2-3yr & 4-5yr visits)</p> <p>✓ if discussed and no concerns</p> <p>Circle if concerns</p> <p>Leave blank if not assessed</p>	<p><u>Nutrition:</u></p> <p><input type="checkbox"/> 1% to 2% milk [~500mL (16oz)/day]</p> <p><input type="checkbox"/> Limit 100% pure juice to ~120-200mL (4-6 oz) /day</p> <p><input type="checkbox"/> Avoid sweet liquids</p> <p><input type="checkbox"/> Encourage country food</p> <p><input type="checkbox"/> Nunavut’s Food Guide</p> <p><input type="checkbox"/> Vit. D deficiency prevention (review NU protocol)</p> <p><u>Issues:</u></p> <p><input type="checkbox"/> Second-hand smoke / Amauti</p> <p><input type="checkbox"/> <i>No pacifiers</i></p> <p><input type="checkbox"/> <i>Encourage reading</i></p> <p><input type="checkbox"/> Toilet learning</p> <p><input type="checkbox"/> Assess child care / School readiness</p> <p><input type="checkbox"/> Socializing / peer play opportunities</p> <p>Environmental Health including:</p> <p><input type="checkbox"/> Sun exposure/ Sunscreens/ Insect repellent</p> <p><input type="checkbox"/> <i>Pesticide exposure</i></p> <p><input type="checkbox"/> <i>Serum lead if at risk</i></p> <p><input type="checkbox"/> Dental cleaning / Fluoride / Dentist</p> <p><input type="checkbox"/> No OTC cough/cold medn</p> <p><input type="checkbox"/> <i>Complementary/ alternative medicine</i></p> <p><input type="checkbox"/> Active healthy living / Screen time</p> <p><u>Injury Prevention:</u></p> <p><input type="checkbox"/> Car seat (child/booster)/ Amauti</p> <p><input type="checkbox"/> Bike helmets</p> <p><input type="checkbox"/> Choking / safe toys</p> <p><input type="checkbox"/> Carbon monoxide/<i>Smoke detectors</i></p> <p><input type="checkbox"/> Matches</p> <p><input type="checkbox"/> Firearm safety/removal</p> <p><input type="checkbox"/> <i>Bath Safety</i></p> <p><input type="checkbox"/> <i>Water Safety</i></p> <p><u>Behaviour and Family Issues:</u></p> <p><input type="checkbox"/> <i>Discipline / Parenting skills programs</i></p> <p><input type="checkbox"/> Parent/child interaction</p> <p><input type="checkbox"/> Family conflict/stress</p> <p><input type="checkbox"/> High risk children</p> <p><input type="checkbox"/> Siblings</p> <p><input type="checkbox"/> Refer to local community programs, i.e. Wellness programs</p> <p><input type="checkbox"/> Parental fatigue/stress/depression</p>
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Physical Examination and Education & Advice: strength of recommendation based on literature review using Canadian Task Force on Preventative Health Care classification: **Good (bold type)**; *Fair (italic type)*; Consensus (plain type).

See Nunavut Well-Baby Guidelines/Resources