



# Bright Futures Parent Handout 2 Year Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

ASSESSMENT OF LANGUAGE DEVELOPMENT

## Your Talking Child

- Talk about and describe pictures in books and the things you see and hear together.
- Parent-child play, where the child leads, is the best way to help toddlers learn to talk.
- Read to your child every day.
- Your child may love hearing the same story over and over.
- Ask your child to point to things as you read.
- Stop a story to let your child make an animal sound or finish a part of the story.
- Use correct language; be a good model for your child.
- Talk slowly and remember that it may take a while for your child to respond.

TELEVISION VIEWING

## Your Child and TV

- It is better for toddlers to play than watch TV.
- Limit TV to 1–2 hours or less each day.
- Watch TV together and discuss what you see and think.
- Be careful about the programs and advertising your young child sees.
- Do other activities with your child such as reading, playing games, and singing.
- Be active together as a family. Make sure your child is active at home, at child care, and with sitters.

SAFETY

## Safety

- Be sure your child's car safety seat is correctly installed in the back seat of all vehicles.
- There should be no more than a finger's width of space between your child's collarbone and the harness strap.

SAFETY

- Everyone should wear a seat belt in the car. Do not start the vehicle until everyone is buckled up.
- Never leave your child alone in your home or yard, especially near cars, without a mature adult in charge.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so he is not run over.
- Keep your child away from moving machines, lawn mowers, streets, moving garage doors, and driveways.
- Have your child wear a good-fitting helmet on bikes and trikes.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.

TOILET TRAINING

## Toilet Training

- Signs of being ready for toilet training
  - Dry for 2 hours
  - Knows if she is wet or dry
  - Can pull pants down and up
  - Wants to learn
  - Can tell you if she is going to have a bowel movement
- Plan for toilet breaks often. Children use the toilet as many as 10 times each day.
- Help your child wash her hands after toileting and diaper changes and before meals.
- Clean potty chairs after every use.
- Teach your child to cough or sneeze into her shoulder. Use a tissue to wipe her nose.
- Take the child to choose underwear when she feels ready to do so.

TEMPERAMENT AND BEHAVIOR

## How Your Child Behaves

- Praise your child for behaving well.
- It is normal for your child to protest being away from you or meeting new people.
- Listen to your child and treat him with respect. Expect others to do as well.
- Play with your child each day, joining in things the child likes to do.
- Hug and hold your child often.
- Give your child choices between 2 good things in snacks, books, or toys.
- Help your child express his feelings and name them.
- Help your child play with other children, but do not expect sharing.
- Never make fun of the child's fears or allow others to scare your child.
- Watch how your child responds to new people or situations.

## What to Expect at Your Child's 2½ Year Visit

### We will talk about

- Your talking child
- Getting ready for preschool
- Family activities
- Home and car safety
- Getting along with other children

Poison Help: 1-800-222-1222

Child safety seat inspection:  
1-866-SEATCHECK; seatcheck.org



## American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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# Pediatric Worksheet 2 Year to 3 Year Well Child Visit

Name: \_\_\_\_\_

FMP and Sponsor Last Four: \_\_\_\_\_ / \_\_\_\_\_

Date: \_\_\_\_\_

(Patient Label)

**If this is the *FIRST* time you are filling in this form, please complete ALL areas.  
If you have ALREADY completed it, please complete SHADED areas ONLY.**

**No Allergies** Please list any allergies you have (drug, food, latex)

**Clinic Use Only**

BP	/	HT		Visual Acuity: R 20/____ L 20/____ Both 20/____
HR		WT		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain
RR		HC		
TEMP		SpO2		



0  
No Hurt



1  
Hurts  
Little Bit



2  
Hurts  
Little More



3  
Hurts  
Even More



4  
Hurts  
Whole Lot



5  
Hurts  
Worst

*(Please complete information below: If filled out before, list only changes since the last visit.)*

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates) (Circle all that apply)	Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
<p><b>NO Medical Conditions</b></p> <p>Asthma Diabetes Hayfever/Allergies Other:</p>	<p><b>NO History of Surgeries</b></p> <p>Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other:</p>	<p>Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental Illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other:</p>	<p>Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter.</p> <p><input type="checkbox"/> Infant Multivitamin 1 ml per day</p>

Source of Medical Information:  Mother  Father  Patient  Other:

Any Hospitalizations, specialty care, or ER visits since your last appointment?  No  Yes:

Would you say your child's Overall Feeling of health is?  Excellent  Very Good  Good  Fair  Poor

Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?  Yes  No  Decline

Are your child's immunizations up to date?  Yes  Unsure  No

Does your child have a chronic medical or behavioral health problem, and/or physical disability?  No  Yes

Is frequent follow-up support required for the above issues?  No  Yes

Does your child require early interventions or special education services?  No  Yes

Is your child enrolled in the Exceptional Family Member Program?  No  Yes

Is your child  In Day-Care  In-Preschool

Does anyone in the family smoke or is your child exposed to secondhand smoke?  No  Yes

Who does the Child Live With?  Parents  Mother  Father  Other:

Is Sponsor currently deployed:  No  Yes

Is this visit deployment related:  No  Yes

Does your child ride in a car with a car seat or seat belt?  Yes  No

Does your child ride a bike wearing a helmet?  N/A  Yes  No

What is your preferred method for learning:  Verbal  Written  Visual  Hands-On  Other: \_\_\_\_\_

Yes  No - Do you or your child have learning/reading needs?

Yes  No - Are there cultural or religious considerations that affect your child's healthcare?

Yes  No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?

**\*\*PLEASE PROVIDE A GOOD CONTACT NUMBER:** \_\_\_\_\_

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

**Pediatric Worksheet 2 Year to 3 Year Well Child Visit**

**Tuberculosis Screening - Complete at 2-Year and 3-Year Well Child Visits**

Yes  No  Unsure Has a family member or contact had tuberculosis?

Yes  No  Unsure Has a family member had a positive tuberculin skin test?

Yes  No  Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, Western Europe)?

Yes  No  Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

**Lead Screening - Complete at 2-Year Well Child Visit**

Yes  No  Unsure Does your child have a sibling or playmate with Hx of lead poisoning?

Yes  No  Unsure Does your child live in or regularly visit a house or child care facility built before 1950?

Yes  No  Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

Drinks milk?  Yes  No Percentage: \_\_\_\_\_ How many ounces per day?

TV Time: (internet, ipad, tablet, DVD, etc.)  <2h per day TV/Screen Time  
 >2h per day TV/Screen Time. (list items and time spent.)

Exercise:  <1h active play per day  >1h active play per day

MARK ALL THAT APPLY:  Bladder Trained  Bowel Trained  Currently Toilet Training

**If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:**

2-YEARS (24 MONTHS) ***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***	30 MONTHS ***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***	3 YEARS (36 MONTHS) COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)
<input type="checkbox"/> Copies things that you do	<input type="checkbox"/> Plays pretend	<input type="checkbox"/> Self-care skills
<input type="checkbox"/> Plays pretend	<input type="checkbox"/> Plays with other children (eg. Tag)	<input type="checkbox"/> Imaginative play
<input type="checkbox"/> Plays alongside other children	<input type="checkbox"/> Other people can understand what your child is saying half of the time	<input type="checkbox"/> 2-3 sentences
<input type="checkbox"/> Puts 2 words together ("my book")	<input type="checkbox"/> When talking, puts 3 or 4 words together	<input type="checkbox"/> Usually understandable
<input type="checkbox"/> Follows two-step commands	<input type="checkbox"/> Points to 6 body parts	<input type="checkbox"/> Names a friend
<input type="checkbox"/> Stacks 5 or 6 small blocks	<input type="checkbox"/> Knows correct animal sounds (eg. Cat meows, dog barks)	<input type="checkbox"/> Names objects
<input type="checkbox"/> Kicks a ball	<input type="checkbox"/> Jumps up and down in place	<input type="checkbox"/> Knows if boy or girl
<input type="checkbox"/> Walks up and down steps one step at a time while holding wall or railing	<input type="checkbox"/> Puts on cloths with help	<input type="checkbox"/> Builds tower (6-8 blocks)
<input type="checkbox"/> Throws overhand	<input type="checkbox"/> Washes and dries hands without help	<input type="checkbox"/> Throws ball overhand
<input type="checkbox"/> Jumps up	<input type="checkbox"/> Brushes teeth with help	<input type="checkbox"/> Walks upstairs alternating feet
<input type="checkbox"/> Turns pages one at a time		<input type="checkbox"/> Copies circle
		<input type="checkbox"/> Draws person (2 body parts)
		<input type="checkbox"/> Toilet trained during day

----- (This section NOT for patient use) -----

**Treatments orders for this visit - Ensure Patients Name and last four on Front of Document:**

<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Ear Irrigation	<input type="checkbox"/> CBC	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Bilirubin (T/D)	<input type="checkbox"/> CXR
<input type="checkbox"/> RSV Swab	Left --- Right	<input type="checkbox"/> UA	<input type="checkbox"/> HbA1c	<input type="checkbox"/> TsBill	<input type="checkbox"/> EKG
<input type="checkbox"/> Strep Screen/TCx	<input type="checkbox"/> Saline Bulb Suction	<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> TSH,T4	<input type="checkbox"/> Monospot	
<input type="checkbox"/> Tussin Swab	<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> BMP	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Dex	<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> CMP	<input type="checkbox"/> Lead		
<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE	<input type="checkbox"/> PPD	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Immunizations - 2-Year: Hep A #2					

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE \_\_\_\_\_ SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

AH

LTA was not accessible during this patient visit. Reviewed note & agree \_\_\_\_\_ (Provider Initial)

VISIT FOR: : Well Child Visit     24 Month     30 Month     36 Month

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Syncope
<input type="checkbox"/> Headache	<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Rash	<input type="checkbox"/> Wheezing- worse with a cold
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Cough with exercise
<input type="checkbox"/> Earache	<input type="checkbox"/> Hearing Concerns	<input type="checkbox"/> Nighttime Cough
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Snoring	<input type="checkbox"/> Daytime Cough
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Emotional Lability
<input type="checkbox"/> Cough	<input type="checkbox"/> Urinary Habits Change	<input type="checkbox"/> Tics
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Recent Unintentional Wt. Loss
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Trouble Falling Asleep
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Limb Pain	<input type="checkbox"/> Sleep Disturbance

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	<b>General:</b>	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	<b>Head/Neck:</b>	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	<b>Eyes:</b>	<input type="checkbox"/> EOMI, RR X2, nl corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	<b>R ear:</b>	<input type="checkbox"/> nl pinna/ext ear canal <input type="checkbox"/> TM gray/nl landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>L ear:</b>	<input type="checkbox"/> nl pinna/ext ear canal <input type="checkbox"/> TM gray/nl landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>Nose:</b>	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist, no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	<b>Lungs:</b>	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/> wheeze <input type="checkbox"/> retractions
<input type="checkbox"/>	<b>CV:</b>	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/> murmur
<input type="checkbox"/>	<b>Abd:</b>	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	<b>Ext/Spine:</b>	<input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple	<input type="checkbox"/>
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/> generalized dry skin
<input type="checkbox"/>	<b>Hips:</b>	<input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani (4m) <input type="checkbox"/> Galleazzi's sign <input type="checkbox"/> Symmetric skin folds (4-24m)	<input type="checkbox"/>
<input type="checkbox"/>	<b>Neuro:</b>	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	<b>Genitalia:</b>	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L	<input type="checkbox"/>
<input type="checkbox"/>	<b>Other findings:</b>	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:

A/P :     Well Child: normal growth & development for age

F/U: at next well child visit at \_\_\_ months, sooner if parental concerns

- Patient and/or parent verbalizes understanding of treatment and plan
- Anticipatory guidance/Prevention handout provided

## M-CHAT-R™

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

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

## LEAD EXPOSURE RISK ASSESSMENT QUESTIONNAIRE

**PRIVACY ACT STATEMENT:**

**Authority:** 5 U.S.C. 301, Departmental Regulations; 10 U.S.C. 1095, Collection from Third Party Payers Act; 10 U.S.C. 5131 (as amended); 10 U.S.C. 5132; 44 U.S.C. 3101; and E.O. 9397 (SSN).

**Purpose:** Used by official, employees and contractors of the Department of the Navy (and members of the National Red Cross in naval medical treatment facilities) in the performance of their official duties relating to the health and medical treatment of Navy and Marine Corps members; research studies and compilation of statistical data; implementation of preventive medicine programs and occupational health surveillance programs.

**Use:** By medical professionals in the performance of official duties. Administrative/Web personnel will have access for purposes of maintaining the data base and inclusion into the medical record.

**Disclosure:** Disclosure of the requested information is voluntary; however, non disclosure may result in an inability to document medical records.

**1. Child Information**

a. Name	b. Date of Birth (DD MMM YYYY)
---------	--------------------------------

**2. Address Information**

a. Street			
b. City	c. State	d. ZIP Code	
e. Housing Area or Subdivision		f. Address Type <input type="checkbox"/> Military <input type="checkbox"/> Nonmilitary	

**3. Does your child: (Select one answer for each question)**

a. Live in a house that was built before 1950?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
b. Live in or regularly visit a house, day care center, or preschool that was built before 1980 which has peeling or chipping paint, or is undergoing renovation or remodeling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
c. Have a brother, sister, housemate, or playmate who has or once had lead poisoning or a high blood lead level?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
d. Live or spend time with someone whose job or hobbies involve exposure to lead (examples: reloading ammunition, making fishing weights, making ceramics, making stained glass, working at a firing range, working with industrial or shipboard paint removal, working with electrical or torch soldering, making soft metal castings)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
e. Live or spend time near any location that you think might release lead (lead smelter, radiator shop, battery recycler, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
f. Live in or regularly visit a house, day care center, or preschool that was identified by a DoD inspection team as a major risk for lead?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
g. Use, play with, or used to play with a toy or other object that was recalled or identified as having high-lead paint?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

**4. Medical Treatment Facility:**

If the child is "high risk" (i.e., if any answer is "yes" or any "don't know" answer is determined by a physician to be "yes"), forward a copy of this form with the blood lead level result to Preventive Medicine. Provide the child's parent or guardian with a note (see Web site: <http://www.cdc.gov/nceh/lead/lead.htm> for guidance) indicating potential exposure to lead.

Completed By Name	Signature	Date
Reviewed By Name	Signature	Date

**Patient Identification** (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; DOB; Rank/Grade.)

Hospital or Medical Facility
Sponsor's Name
SSN/ID No.

# PEDS RESPONSE FORM

Provider \_\_\_\_\_

Child's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

Child's Birthday \_\_\_\_\_ Child's Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.



## Questions about your child's development?

### **Educational & Developmental Intervention Services (EDIS)**

is a program for infants and toddlers (birth to 36 months) who have:

- medical conditions which may affect development  
(such as complications of prematurity, hearing or visual impairment)
- developmental delay (for example, not walking or talking as expected)  
or atypical development
- genetic conditions

**Educational & Developmental Intervention Services** provides:

- in-home services
- basic services are free to eligible children:
  - \* developmental evaluation (includes physical, communication, problem-solving, self-help, and social-emotional skills)
  - \* in-home training for parents on encouraging child's development
  - \* service coordination (helps parents access other services)

### **Parents can refer their children!**

*To make a referral, call:*

(for families living on base:)

**Educational & Developmental  
Intervention Services**  
Location: NH200 Annex  
Naval Hospital Camp Lejeune  
Mailing Address:  
EDIS  
100 Brewster Blvd  
Camp Lejeune, NC 28547  
910 450 4127

(for families living off base:)

**Children's Developmental Services Agency**  
2842 Neuse Blvd  
New Bern, NC 28562  
866 KIDS N NC (toll free)  
866 543 7662