



# Bright Futures Parent Handout 3 Year Visit

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

ENCOURAGING LITERACY ACTIVITIES

## Reading and Talking With Your Child

- Read books, sing songs, and play rhyming games with your child each day.
- Reading together and talking about a book's story and pictures helps your child learn how to read.
- Use books as a way to talk together.
- Look for ways to practice reading everywhere you go, such as stop signs or signs in the store.
- Ask your child questions about the story or pictures. Ask him to tell a part of the story.
- Ask your child to tell you about his day, friends, and activities.

PROMOTING PHYSICAL ACTIVITY

## Your Active Child

Apart from sleeping, children should not be inactive for longer than 1 hour at a time.

- Be active together as a family.
- Limit TV, video, and video game time to no more than 1–2 hours each day.
- No TV in your child's bedroom.
- Keep your child from viewing shows and ads that may make her want things that are not healthy.
- Be sure your child is active at home and preschool or child care.
- Let us know if you need help getting your child enrolled in preschool or Head Start.

FAMILY SUPPORT

## Family Support

- Take time for yourself and to be with your partner.
- Parents need to stay connected to friends, their personal interests, and work.
- Be aware that your parents might have different parenting styles than you.
- Give your child the chance to make choices.
- Show your child how to handle anger well—time alone, respectful talk, or being active. Stop hitting, biting, and fighting right away.
- Reinforce rules and encourage good behavior.
- Use time-outs or take away what's causing a problem.
- Have regular playtimes and mealtimes together as a family.

SAFETY

## Safety

- Use a forward-facing car safety seat in the back seat of all vehicles.
- Switch to a belt-positioning booster seat when your child outgrows her forward-facing seat.
- Never leave your child alone in the car, house, or yard.
- Do not let young brothers and sisters watch over your child.
- Your child is too young to cross the street alone.
- Make sure there are operable window guards on every window on the second floor and higher. Move furniture away from windows.
- 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. Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Supervise play near streets and driveways.

PLAYING WITH PEERS

## Playing With Others

Playing with other preschoolers helps get your child ready for school.

- Give your child a variety of toys for dress-up, make-believe, and imitation.
- Make sure your child has the chance to play often with other preschoolers.
- Help your child learn to take turns while playing games with other children.

## What to Expect at Your Child's 4 Year Visit

### We will talk about

- Getting ready for school
- Community involvement and safety
- Promoting physical activity and limiting TV time
- Keeping your child's teeth healthy
- Safety inside and outside
- How to be safe with adults

Poison Help: 1-800-222-1222

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



American Academy  
of Pediatrics



The recommendations in this publication do not constitute an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Bright Futures Tool and Resource Kit. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and, therefore, shall not be liable for any such changes.

DEDICATED TO THE HEALTH OF ALL CHILDREN™

## 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		

(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)
NO Medical Conditions  Asthma Diabetes Hayfever/Allergies Other:	NO History of Surgeries  Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other:	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:	Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter  <input type="checkbox"/> Infant Multivitamin 1 ml per day

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)	30 MONTHS	3 YEARS (36 MONTHS)
***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***	***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***	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:**

Flu Swab       Ear Irrigation       CBC       Chol Panel       Bilirubin (T/D)       CXR

RSV Swab      Left --- Right       UA       HbA1c       TsBill       EKG

Strep Screen/TCx       Saline Bulb Suction       CRP/ESR       TSH,T4       Monospot

Tussin Swab       Motrin (PO) \_\_\_\_\_ mg       BMP       Iron Profile       EBV Titers

Dex       Tylenol (PO) \_\_\_\_\_ mg       CMP       Lead

EVALUATE FOR VACCINE UPDATE       PPD       Other \_\_\_\_\_

Immunizations - 2 Year: Hep A #2

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

**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"/> Galeazzi'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

# 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.