



# Bright Futures Parent Handout 5 and 6 Year Visits

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

ORAL HEALTH

## Healthy Teeth

- Help your child brush his teeth twice a day.
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss her teeth once a day.
- Your child should visit the dentist at least twice a year.

SCHOOL READINESS

## Ready for School

- Take your child to see the school and meet the teacher.
- Read books with your child about starting school.
- Talk to your child about school.
- Make sure your child is in a safe place after school with an adult.
- Talk with your child every day about things he liked, any worries, and if anyone is being mean to him.
- Talk to us about your concerns.

MENTAL HEALTH

## Your Child and Family

- Give your child chores to do and expect them to be done.
- Have family routines.
- Hug and praise your child.
- Teach your child what is right and what is wrong.
- Help your child to do things for herself.
- Children learn better from discipline than they do from punishment.
- Help your child deal with anger.
  - Teach your child to walk away when angry or go somewhere else to play.

NUTRITION AND PHYSICAL ACTIVITY

## Staying Healthy

- Eat breakfast.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Limit candy, soft drinks, and high-fat foods.
- Offer 5 servings of vegetables and fruits at meals and for snacks every day.
- Limit TV time to 2 hours a day.
- Do not have a TV in your child's bedroom.
- Make sure your child is active for 1 hour or more daily.

SAFETY

## Safety

- Your child should always ride in the back seat and use a car safety seat or booster seat.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Have a working smoke alarm on each floor of your house and a fire escape plan.
- Install a carbon monoxide detector in a hallway near every sleeping area.
- 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.
- Teach your child how to cross the street safely. Children are not ready to cross the street alone until age 10 or older.
- Teach your child about bus safety.
- Teach your child about how to be safe with other adults.
  - No one should ask for a secret to be kept from parents.
  - No one should ask to see private parts.
  - No adult should ask for help with his private parts.

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 4 Year to 10 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)	(PLEASE)
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 p including supp vitamins obtai

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  In school GRADE: \_\_\_\_\_  Home-schooled GRADE: \_\_\_\_\_

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

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

Yes  No - Do you or your child have learning/readiness 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 4 Year to 10 Year Well Child Visit

**Complete YEARLY through age 6 years**

- 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?

**Complete YEARLY Tuberculosis Screening**

- 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)?

- Drinks milk?  Yes  No Percentage: \_\_\_\_\_ How many ounces per day? \_\_\_\_\_
- MARK ALL THAT APPLY:  Bladder Trained  Bowel Trained  Currently Toilet Training  Bowel or bladders concerns
- Sleep concerns, difficulties or disturbances:  Unsure  No  Yes:
- Exercise:  <1h active play per day  >1h active play 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.)

Pre-teen/teen females only (if applicable): Last menstrual period \_\_\_\_\_ or  Not Applicable?  
 How many days does her period last? \_\_\_\_\_ How many pads per day? \_\_\_\_\_

**Check all the following that apply to your child and age:**

4 YEARS TO 6 YEARS	7 YEARS TO 8 YEARS	9 YEARS TO 10 YEARS
<input type="checkbox"/> Interactions with peers	<input type="checkbox"/> Eats Healthy Meals and Snacks	<input type="checkbox"/> Eats Healthy Meals and Snacks
<input type="checkbox"/> Fantasy Play	<input type="checkbox"/> Participates in an after school activity	<input type="checkbox"/> Participates in an after school activity
<input type="checkbox"/> Usually understandable	<input type="checkbox"/> Has friends	<input type="checkbox"/> Has friends
<input type="checkbox"/> Names 4 colors	<input type="checkbox"/> Is vigorously active for 1 hour a day	<input type="checkbox"/> Is vigorously active for 1 hour a day
<input type="checkbox"/> Draws person (3 body parts)	<input type="checkbox"/> Is doing well in school	<input type="checkbox"/> Has a caring/supportive family
<input type="checkbox"/> Plays board/card games	<input type="checkbox"/> Does chores when asked	<input type="checkbox"/> Is doing well in school
<input type="checkbox"/> Hops on one foot	<input type="checkbox"/> Gets along with family	<input type="checkbox"/> Is getting chances to make own decisions
<input type="checkbox"/> Balance on one foot for 2 seconds		<input type="checkbox"/> Feels good about self
<input type="checkbox"/> Builds tower (8 blocks)		<input type="checkbox"/> Does an activity really well; describe:
<input type="checkbox"/> Copies a cross		
<input type="checkbox"/> Brushes own teeth		
<input type="checkbox"/> Dresses self		

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

Attach Pediatric Symptom Checklist if completed  
 Attach SCARED if completed

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

- Flu Swab
- Ear Irrigation
- CBC
- Chol Panel
- Billirubin (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 - 11 YEARS AND UP – Tdap, MCV-4, HPV (optional)

# Pediatric Worksheet 4 Year to 10 Year Well Child Visit

## CHRONOLOGICAL RECORD OF MEDICAL CARE

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

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

VISIT FOR: : Well Child Visit  4 Years  5 Years  6 Years  7 Years  8 Years  9 Years  10 Years

HPI:

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

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

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"/> Boggy mucosa
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist <input type="checkbox"/> Tonsils normal	<input type="checkbox"/> Large tonsils
<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:</b>	<input type="checkbox"/> NL, FROM, nontender, no cyanosis, no clubbing, no edema	<input type="checkbox"/>
<input type="checkbox"/>	<b>Spine:</b>	<input type="checkbox"/> Straight	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> Normal skin <input type="checkbox"/> no rash	<input type="checkbox"/> generalized dry skin
<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 <input type="checkbox"/> NI male, Testes down B/L Tanner Stage: _____ <input type="checkbox"/> No hernia B/L	<input type="checkbox"/>
<input type="checkbox"/>	<b>Other findings:</b>	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:

## Pediatric Worksheet 4 Year to 10 Year Well Child Visit

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

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

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

Child's Name \_\_\_\_\_  
 Today's Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

Record Number \_\_\_\_\_  
 Filled out by \_\_\_\_\_

### Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____
2.	Spends more time alone	2	_____	_____
3.	Tires easily, has little energy	3	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____
5.	Has trouble with a teacher	5	_____	_____
6.	Less interested in school	6	_____	_____
7.	Acts as if driven by a motor	7	_____	_____
8.	Daydreams too much	8	_____	_____
9.	Distracted easily	9	_____	_____
10.	Is afraid of new situations	10	_____	_____
11.	Feels sad, unhappy	11	_____	_____
12.	Is irritable, angry	12	_____	_____
13.	Feels hopeless	13	_____	_____
14.	Has trouble concentrating	14	_____	_____
15.	Less interest in friends	15	_____	_____
16.	Fights with others	16	_____	_____
17.	Absent from school	17	_____	_____
18.	School grades dropping	18	_____	_____
19.	Is down on him or herself	19	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____
21.	Has trouble sleeping	21	_____	_____
22.	Worries a lot	22	_____	_____
23.	Wants to be with you more than before	23	_____	_____
24.	Feels he or she is bad	24	_____	_____
25.	Takes unnecessary risks	25	_____	_____
26.	Gets hurt frequently	26	_____	_____
27.	Seems to be having less fun	27	_____	_____
28.	Acts younger than children his or her age	28	_____	_____
29.	Does not listen to rules	29	_____	_____
30.	Does not show feelings	30	_____	_____
31.	Does not understand other people's feelings	31	_____	_____
32.	Teases others	32	_____	_____
33.	Blames others for his or her troubles	33	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____
35.	Refuses to share	35	_____	_____

Total score \_\_\_\_\_

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y  
 Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? \_\_\_\_\_

# 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.