Dear Parent or Guardian,

You have received this pre-screening document to complete as part of your participation in the Healthy Young Athletes Pdiatric Screening. The Healthy Young Athletes Pediatric Screening is meant to support the healthcare and developmental needs of your child. This screening will provide information, tools, and direct referrals to local community healthcare and related providers and services. This is intended to enhance, not replace, existing support and services with which you are already engaged.

This screening and consultation are part of the [Special Olympics Young Athletes](https://www.specialolympics.org/our-work/inclusive-health/young-athletes) program.  Whether your child has been participating in Young Athletes on a regular basis or this is your first time at a Special Olympics event, we thank you for completing the information in this pre-screening.

Once the pre-screening questionnaire is complete, your information will be shared with a designated clinical director at your local Special Olympics Program. At the Healthy Young Athletes Pediatric Screening, you and your child will receive a comprehensive screening and consultation to address any areas of need or gaps in care and development.  As a result of the screening, your child may receive a referral for follow-up care with a local provider or specialist. Many families will also receive additional educational information to support ongoing health and development of their child.

Your answers to the pre-screening will help us to explore ways to promote your child and family’s strengths, as well as to identify potential areas of need prior to the full screening and consultation event. This screening tool was developed to ***journey with you*** in providing the best for your child!

Answers to questions in the pre-screening and at the screening and consultation event are all optional. Share information you feel comfortable with and if you are not sure about how to answer a question, leave that space blank. The Special Olympics staff or volunteer seeing you during the face-to-face screening and consultation will review any confusing questions with you, as well as any areas that require more discussion.

Special Olympics welcomes you as you embark on this deep dive into the health and wellbeing needs of your child.  Every child deserves the attention, support, and services of qualified healthcare professionals. It is our goal to work with you as you navigate the system and provide ongoing support, so your child lives a long healthy active life.

**YOUNG ATHLETES**

**HEALTHY START PEDIATRIC SCREENING (Global)**

|  |
| --- |
| Name of child:Child’s Date of Birth:Name of Parent:Parent Phone Number:Parent Email:Special Olympics Program Location (Country):Language spoken at home:Needs wheelchair accessible locations for in-person events:1.What are your child’s greatest strengths? ***Please check all that apply**** Independent
* Playful
* Happy
* Social
* Patient
* Calm

Please provide more details in the space below:2. Please list some fun facts about your child e.g. what activities/places/animals make them happy, what soothes them, what is their favorite toy, character etc.1. 3. What aspects of your child’s health and development are you most concerned about? ***Please check all that apply***
* Suspected medical illness
* Adaptive skills (toilet training, self-grooming)
* Dental health
* Vision
* Hearing
* Other
* Tantrums/emotional regulation/Behavioral issues
* Social skills
* Language/communication
* Nutrition/Feeding/weight
* Sleep patterns/habits

4. My child is currently being assessed for the following medical, developmental, behavioral and/or emotional concerns |

**CHILD HEALTH CARE HISTORY**

5. When was the *last time* your child had the following? ***Please check all that apply***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Month | Year | Too long to remember | Never |
| Well child check-up/ regular physical |  |  |  |  |
| Check-up with dentist |  |  |  |  |
| Hearing test: type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Normal
* Abnormal
 |  |  |  |  |
| Vision test (includes any specialized testing)* Normal
* Abnormal
 |  |  |  |  |
| How would you describe your child’s vaccination status?(Please upload your child’s vaccine records or bring them with you to the pediatric screening event) | * Fully vaccinated/up to date
* Partially vaccinated
* Not vaccinated
 |
| If your child is not fully vaccinated kindly list the missed vaccines below: |

6. What types of therapies/ additional support does your child currently have? ***Please check all that apply***:

* Physical therapy
* Occupational therapy
* Speech/ language therapy
* Feeding therapy
* Dietitian/ nutrition
* Special School/ Therapeutic School
* Developmental/ Behavioral therapy
* Other \_\_\_\_\_\_\_\_\_\_\_

**CHILD MEDICAL HISTORY**

|  |
| --- |
| 7. Has your child ever been diagnosed with any of the following conditions? Please check ***all that apply***:  |
| **Medical illness:** * Yes, specify
* No

**Neurologic Conditions*** Cerebral Palsy
* Traumatic brain Injury or Bleed
* Stroke (low oxygen, blood flow, or clot to brain)
* Meningitis or other brain infection
* Hydrocephalus (fluid build-up in the brain)
* Seizures / Epilepsy

**Dental*** Cavities
* Gum infection
 | **Eyes & Vision:** * wandering/ lazy eye
* Problems seeing
* Blindness (including legal blindness)

**Ears & Hearing:** * Hearing Loss
* Repeat ear infections

**Genetic Syndromes** * Down Syndrome
* Fragile X Syndrome
* Other,specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other conditions not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**CHILD DEVELOPMENTAL/ BEHAVIORAL/ EMOTIONAL HISTORY**

|  |
| --- |
| 8. Are you concerned/ have you ever been told that your child hasany of the following? Please check ***all that apply***: |
| **Developmental Delays:** * Delay in speech/ language/ communication
* Delay in fine motor skills (use of fingers and hands)
* Delay in gross motor skills (large movements to get to places)
* Delay in problem-solving, thinking, reasoning.
* Delay in social-emotional skills.
 | **Developmental Diagnoses** * Autism/ Autism Spectrum Disorders (ASD)
* Fetal Alcohol Syndrome (FAS)
* Global developmental delays
* Intellectual Disability (ID)
* Learning Disability
* Attention Deficit Hyperactivity Disorder (ADHD)

**Mental Health Diagnoses:** * Anxiety
* Depression
 |
| * Other conditions not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 9. Do you worry that your child is **being bullied** by other children or adults?  (this includes both verbal and physical aggression) O yes. O no.  |

**ENVIRONMENT/ SAFETY/ RESOURCES**

This next section includes standard questions recommended by pediatric experts at all health visits. All these social and environmental issues can affect health and development. Feel *free to skip* over any questions you prefer not to answer.

|  |
| --- |
| 10. Please check all that apply: * In the last 12 months, I (parent) or my child ate less than I felt I/we should because there wasn’t enough money for food.
* Do you currently use/have access to a food support program?
* Yes
* No
* I am worried that in the next 3 months, I may not have stable housing.
* In the last 12 months, the electric, gas, oil, or water company has threatened to shut off services to my home.
* In the last 12 months, transportation problems caused someone in my household to miss needed healthcare.
* My child lives in, or regularly visits, a home that increases their exposure risk to lead)
* My child lives with someone who smokes or vapes (e.g. cigarettes, e-cigarettes, jules, pot, cannabis).
* None of the above
 |
| 11. What has been your experience with medical insurance for your child? Please check all that apply:   * In the last 12 months, I felt that my child needed to see a doctor but could not do so due to cost.
* I have had difficulty obtaining insurance coverage for my child.
* My insurance does not provide adequate coverage for my child’s needs.
* None of the above
 |

**CURRENT/ ONGOING BEHAVIORAL/EMOTIONAL CONCERNS.**

|  |
| --- |
| ***PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST*** |
| These questions are about your child’s behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child (*tick the most accurate response)* |
| **Does your child…** | **Not at all****(0)** | **Somewhat****(1)** | **Very much****(2)** |
| Seem nervous or afraid? |  |  |  |
| Seem sad or unhappy? |  |  |  |
| Get upset if things are not done in a certain way?  |  |  |  |
| Have a hard time with change? |  |  |  |
| Have trouble playing with other children |  |  |  |
| Break things on purpose? |   |   |  |
| Fight with other children? |  |  |  |
| Have trouble paying attention? |  |  |  |
| Have a hard time calming down? |  |  |  |
| Have trouble staying with one activity? |  |  |  |
| **Is your child…** |  |  |  |
| Aggressive? |  |  |  |
| Fidgety or unable to sit still? |  |  |  |
| Angry? |  |  |  |
| **Is it hard to…** |  |  |  |
| Take your child out in public? |  |  |  |
| Comfort your child? |  |  |  |
| Know what your child needs? |  |  |  |
| Keep your child on a schedule or routine? |  |  |  |
| Get your child to obey you? |  |  |  |

|  |
| --- |
| **Child’s Physician and Insurance Information** |
| Physician’s name  |  |
| Physician’s Phone Number |  |
| Insurance Name |  |
| Insurance Policy Number |  |
| Insurance Group Number |  |

|  |
| --- |
| **Parent Emotional Health** ***(This section is optional for parents/caregivers to complete)***Parenting can be stressful. Pediatric health experts recommend asking the following questions to identify any emotional needs and help connect you with educational resources and mental health professionals.  |
| Over the last 2 weeks, how often have you (parent) been bothered by any of the following problems?    | Not at all  | Several  days  | More than ½ the days  | Nearly every day  |
| Little interest or pleasure in doing things  | 0  | 1  | 2  | 3  |
| Feeling down, depressed, or hopeless  | 0  | 1  | 2  | 3  |

**Healthy Young Athletes CONSENT**

Special Olympics offers certain non-invasive health care services to athletes at local, state, national, and World Games venues through the Healthy Athletes® Program. These services may include individual assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised of the need for follow-up care. In addition, information collected at the time that services are provided has been invaluable for developing policies, securing resources, and implementing programs to better meet the health needs of athletes.

**Authorization for Minors:** I understand that by signing below I consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (athlete’s full name) participation in the Special Olympics Healthy Athletes Special Smiles program that provides individual screening assessments of oral health. I understand there is no obligation for the athlete named above to participate in the Healthy Athletes Program should the athlete decide not to participate or should I decide the athlete shall not participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services for the athlete named above and that Special Olympics is not through the provision of these provisions responsible for the health of the athlete named above. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

**Authorization for Parents/Guardian**: By signing below I understand that I am not obliged to answer any questions regarding my emotional/mental health. I also give permission for my responses to be shared with a healthcare provider if there is need for further evaluation or support. I understand that I bare the ultimate responsibility for following up with the healthcare provider. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the needs of athletes’ parents/guardians and to develop programs to address those needs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if athlete is under 18 years old)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Special Olympics Program Date

**Healthy Young Athletes In-person Screening**

***Completed by Trained Volunteer at Event***

**Name of Child:**

**Name of Biometrics Volunteer:**

**BIOMETRICS**

|  |
| --- |
| * WHO/ CDC growth chart
* Downs Syndrome growth chart
* Other growth chart used, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  | % for age |
| Weight\*\* | kg | lb | % |
| Height\*\** Unable to obtain:
 | cm | in | % |
| Body Mass Index (BMI) |  | % |
| Head Circumference | cm | in | % |

**VACCINE RECORDS**

*Kindly review the child’s vaccination records as provided by the parent/caregiver*

|  |  |
| --- | --- |
| Is the child up to date on CDC/WHO recommended childhood vaccines? | * Yes
* No
 |
| If not, please indicate the missed vaccines below* Hepatitis B (HepB)
* Rotavirus (RV)
* Diphtheria,tetanus,acellular pertussis (DTaP)
* H. Influenzae type b (Hib)
* Pneumococcal conjugate (PCV13)
 | * Inactivated poliovirus (IPV)
* Measles,mumps,rubella (MMR)
* Varicella (VAR)
* Hepatitis A (HepA)
* Influenza
* Covid-19
 |

**VITAL SIGNS**

|  |  |  |  |
| --- | --- | --- | --- |
| Temperature (degree C) |  | * normal
 | * Elevated
 |
| Pulse | Beats per minute | * Normal Elevated
 | * low
 |
| Right Arm Blood Pressure | mmHg  | %ile  | * normal
 | * Elevated
 | * low
 |
| Leg blood pressure(*to be checked if elevated blood pressure is noted in the right arm)* | mmHg  | %ile  | * normal
 | * Elevated
 | * low
 |
| Pulse-Oximetry  | %  | * normal
 | * low
 |

**VISUAL SCREEN**

|  |
| --- |
| Does your child currently use corrective lenses? |
| Is your child already scheduled to see an eye doctor? |
| **Examination** |
| **Eyes****Right \_\_\_\_\_\_****Left \_\_\_\_\_\_*** Normal
 |  |
| * Ptosis
* Bluish or gray sclera
* Iris spots/discoloration
* Corneal spots/discoloration
 | * Red reflex:

O. Normal* + 1. O. Abnormal
 | * Asymmetric pupillary reactivity
* Diminished or asymmetric extraocular movements. “
* Abnormal horizontal nystagmus
* Vertical nystagmus
 |
| **Visual tests** *(record findings)* | Left eye | Right eye | Pass | Refer |
| Lea symbols chart |  |  |  |  |
| PlusOptix |  |  |  |  |
| GoCheck Kids |  |  |  |  |
| Stereopsis test |  |  |  |  |
| Autorefractor |  |  |  |  |
| Fundus camera |  |  |  |  |

**AUDIO SCREEN**

|  |
| --- |
| Is your child currently using hearing aids? |
| Has your child had surgery in the past, to correct hearing loss (cochlear implant)? |
| **Examination (***check all that apply)* |  | Left ear | Right ear |
| External inspection | Signs of external ear infection  |  |  |
| Otoscopic examination | wax/cerumen impaction |  |  |
|  | Tympanic membrane perforation |  |  |
|  | Tympanic membrane air/fluid level or effusion |  |  |
|  |  | Pass | Fail |
| Otoacoustic Emission test |  |  |  |

**DENTAL STATION**

*(Provide oral hygiene education in this station)*

|  |
| --- |
| How many times a day do you clean / help clean your child’s teeth?  |
| How many cavities has your child had in the past? |
| **Does your child…** | Never | Sometimes | Often |
| Fall asleep either nursing or bottle feeding?  |  |  |  |
| Eat/drink sugary foods/drinks e.g juice, soda, candy, chocolates |  |  |  |
| Report any pain/sensitivity in the mouth? |  |  |  |
| Have bleeding gums |  |  |  |
| **Examination**  |
| **Dentition*** Normal
 |  |
| * Erythematous, swollen gingiva
* Gum bleeding
* Teeth pitting or odd shape
* Hypodontia for age
* Malocclusion/ crowding
 | * White/ chalky spots on teeth
* Obvious caries/cavities
* Detail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**DEVELOPMENTAL SURVEILLANCE**

**Name of Child:**

**Name of Developmental Surveillance Volunteer:**

***Social-Emotional Area***

Social-emotional skills are important for connecting with others. They help the child to manage their emotions, build healthy relationships and to behave in a socially acceptable manner.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Does your child…*** | ***Not yet*** | ***Sometimes***  | ***Yes***  | ***Progression determination*** |
| 1. Smile back when you talk to or smile at him/her?
 |  |  |  | *02-months* |
| 1. Is your child shy, clingy, or fearful around strangers? Or react when you leave?
 |  |  |  | *09-months* |
| 1. Look at you when you call his/ her name?
 |  |  |  | *9 months* |
| 1. Point to show you something interesting (not just to make it work)?
 |  |  |  | *18 months* |
| 1. Notice when others are hurt or upset, like pausing or looking sad when someone is crying?
 |  |  |  | *24 months* |
| 1. Does your child look at your face to see how to react in a new situation?
 |  |  |  | *24-months* |
| 1. Notice other children and attempt to join them in play?
 |  |  |  | *3-years* |
| 1. Asks to go play with children if none are around (e.g. “Can I play with X?”
 |  |  |  | *4 years* |
| 1. Follows rules or takes turns when playing games with other children.
 |  |  |  | *5 years* |
| 1. Does your child have friends at school and talk about them with you?
 |  |  |  | *6-7 years* |

***Language & Communication Area***

Language is a set of sounds, words, gestures, etc. that have meaning. Communication involves people understanding information that is directed toward them and being able to share information with others through sounds, words, gestures, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Does your child…*** | ***Not yet*** | ***Sometimes*** | ***Yes*** | ***Progression determination*** |
| 1. Take turns making sounds with you?
 |  |  |  | *6 months* |
| 1. Does your child make different sounds with consonants, e.g., “mamama,” “bababa”?
 |  |  |  | *9 months* |
| 1. Call a parent “mama” or “dada” or another special name
 |  |  |  | *12-months* |
| 1. Follows 1-step directions without gestures, like giving you the toy when you say, “Give it to me.”
 |  |  |  | 18 months |
| 1. Say 2+ words in a sentence, like “doggie run.”
 |  |  |  | 30 mos |
| 1. Speak well enough for strangers to understand most of (75%) what he or she says?
 |  |  |  | 3 years |
| 1. Answer simple questions (e.g. “What is a coat for”.)
 |  |  |  | 4-years |
| 1. Talk with you in conversation using at least 2 back and forth exchanges?
 |  |  |  | *5 years* |
| 1. Tells a story she heard or made up with at least 2 events (like a cat stuck in a tree and a firefighter saving it)
 |  |  |  | *5 years* |
| 1. Does your child read books targeted for age/ grade level?
 |  |  |  | *6-7 years* |

**Thinking, Reasoning and Problem-Solving Area**

Children are natural problem solvers. They use their thinking and reasoning skills to better understand it. Initially, they do this on a trial-and-error basis. As a child develops and becomes a more experienced problem-solver, they use past experiences to help them solve new problems.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Does your child…*** | ***Not yet*** | ***Sometimes*** | ***Yes*** | ***Progression determination*** |
| 1. Reach to grab something he or she wants?
 |  |  |  | *6 months* |
| 1. Look for things he sees you hide (e.g. toy under blanket)?
 |  |  |  | *12 months* |
| 1. Tries to use things the right way (like phone, cup, book).
 |  |  |  | *15 months* |
| 1. Copy you doing chores, e.g. sweeping with a broom)?
 |  |  |  | *18 months* |
| 1. Try to use switches, knobs, buttons on a toy? (or explore how a toy works?)
 |  |  |  | *24 months* |
| 1. Follow 2-step directions, like “Put the toy down, then close the door”?
 |  |  |  | *30 months* |
| 1. Avoid touching hot objects, like a stove, when you warn him/ her?
 |  |  |  | *3 years* |
| 1. Names a few colors of items.
 |  |  |  | *4 years* |
| 1. Use words about time, like yesterday, tomorrow, morning, or night?
 |  |  |  | *5 years* |
| 1. Follow a multi-step daily routine (e.g., get ready for school – eat breakfast, brush teeth, get dressed, etc.)?
 |  |  |  | *7-9 years*  |
| 1. Avoid common dangers in the community (e.g., stopping at a red light, looks both ways when crossing the street)?
 |  |  |  | *7-9 years*  |

***Fine Motor Area***

Motor development refers to the growth and strengthening of a child’s bones, muscles and ability to interact with their surroundings. Fine motor skills refer to small movements of hands, feet, fingers, toes etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Does your child…*** | ***Not yet*** | ***Sometimes*** | ***Yes*** | ***Progression determination*** |
| 1. Pick things up between thumb and pointer finger, like small bits of food?
 |  |  |  | *12 months* |
| 1. Drink from a cup without lid by him/herself? (may spill at times)
 |  |  |  | *18 months* |
| 1. Scribble with a crayon or other writing tool?
 |  |  |  | *18 months* |
| 1. Feed himself/herself with spoon?
 |  |  |  | *24 months* |
| 1. Takes some clothes off by him/herself, like loose pants of an open jacket?
 |  |  |  | *30 months* |
| 1. Puts **on** some clothes by self like loose pants or a jacket
 |  |  |  | *3 years* |
| 1. Hold crayons or other writing tool between thumb and fingers (not fist)?
 |  |  |  | *4 years* |
| 1. Button some buttons?
 |  |  |  | *5 years* |
| 1. Form letters of the alphabet correctly, or can begin to use a computer/ type?
 |  |  |  | *7-8 years* |

***Gross Motor Area***

Gross motor skills involve the development of large muscles that enable children to sit, crawl, walk, run, jump, pull themselves up, push themselves, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Does your child…*** | ***Not yet)*** | ***Some*** | ***Yes*** | ***Progression determination*** |
| 1. Sit without support?
 |  |  |  | *9 months* |
| 1. Walk without holding onto anything?
 |  |  |  | *18 months* |
| 1. Run without falling?
 |  |  |  | *24 months* |
| 1. Jumps off ground with both feet?
 |  |  |  | *30 months*  |
| 1. Catch a large ball most of the time?
 |  |  |  | *4 years* |
| 1. Hop on 1 foot?
 |  |  |  | *5 years* |
| 1. Run around obstacles, starts and stops easily?
 |  |  |  | *6 years* |
| 1. Jump rope or jump over other obstacles?
 |  |  |  | *7-8 years* |

**REVIEW OF SYSTEMS**

**Name of Child:**

**Name of Review of Systems, Targeted Surveillance and Physical Exam Volunteer:**

Please check *all that apply*, and add any pertinent details or comments:

|  |  |
| --- | --- |
| **System** | **Symptoms** |
| 1. **GENERAL/ CONSTITUTIONAL**
 | * unplanned / unexpected weight gain (last 6 months)
* unplanned / unexpected weight loss (last 6 months)
 |
| 1. **CARDIOVASCULAR/ PULMONARY**
 | * Ever fainted or passed out with physical exertion, sudden/ loud noises
* Ever had abnormal heart test
* Wheezing, coughing or shortness of breath with colds, at night, or with exercise.
 |
| 1. **NEUROLOGIC**
 | * Headaches that are worse when lying down or that awakens your child from sleep
* Unexplained early morning vomiting
* Unexplained repetitive movements, twitching, shaking, or “spells” (e.g. staring) concerning for seizures
* Short/ sudden movements, twitches, utterances
* Excessively trips, falls, bumps into things due to difficulties with balance and/or coordination
 |
| 1. **ENDOCRINE**
 | * Excessive thirst and/or drinking fluids, excessive urination
* If child has Down S: > 1 yr since last thyroid screen
 |

**NUTRITION & GASTROINTESTINAL**

|  |  |  |
| --- | --- | --- |
| ***Does your child have any of the following:*** |  Yes | No |
| 1. Vomiting, Choking or coughing related to feeds
 |  |  |
| 1. Excessive appetite, eating constantly
 |  |  |
| 1. Loose or watery stools
 |  |  |
| 1. Hard, pellet-like, or rock-like stools
 |  |  |
| 1. Child’s diet restricted due to:
* Excessively picky eating
* Medical restriction, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**SLEEP**

|  |
| --- |
| 1. What time does your child go to bed?
 |
| 1. Does your child have a fixed bedtime routine?
 |
| 1. Does your child go to bed easily?
 |
| 1. Does your child have loud breathing, snoring, or pauses in breathing during sleep?
 |
| 1. Does your child sleep through the night?
 |

**PHYSICAL EXAM**

|  |
| --- |
| **General Observations** |
| **Mental status/ Bx** | * Playful
* Calm
 | * Alert
* Lethargic
 | * Irritable
* Hyperactive
 |  |
| **Child’s interaction with parents and examiner*** Insufficient opportunity to observe
 | * Joint attention
* Reciprocal communication
* Calms with parent
* Good eye contact
* Little or no eye contact
 | * No/ minimal joint attention
* No/ minimal reciprocal communication
* Difficulty calming with parent
* Other concern \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Head/Face** |
| **Face (dysmorphology)*** Normal
 |  |
| * Frontal bossing
* Shortened palpebral fissures
* Epicanthal folds
* Hypertelorism
 | * Flattened nasal bridge
* Flat philtrum
* Thin upper lip
* Small mouth
* Low-set ears
 | * Bilateral or multiple preauricular pits
* Other \_\_\_\_\_\_\_
 |
| **Oropharynx and upper airway*** Normal
 |  |
| * Pharyngeal Inflammation
* Tonsils Grade 3-4
 | * Cleft palate +/- lip
 |
| **Core/ Trunk** |
| **Heart &** **Cardiovascular*** Normal
 |  |
| * Abnormal systolic murmur

Location\_\_\_\_\_\_Grade\_\_\_\_\_\_\_Radiation\_\_\_\_\_ | * Diastolic murmur
* Single loud S2
 |
| **Lungs & Upper Airway*** Normal
 |  |
| * Wheeze
* Rales
* Rhonchi
* Diminished air movement: detail \_\_\_\_\_\_\_\_
 | * Stridor:

O At rest O. Only with agitation O Continuous |
| **Abdomen*** Normal
 | * Hepatomegaly
* Splenomegaly
* Mass: size \_\_\_\_\_\_\_\_ location \_\_\_\_\_\_\_
 |
| **Muskuloskeletal Exam** |
| **Chest/ ribs*** Normal
 | * Pectus excavatum
* Pectus carinatum
* Shield chest or widely spaced nipples
 | **Spine*** Normal
 | * Lordosis
* Kyphosis
* Scoliosis
 |
| **Upper extremities****Arms and hands****Shoulders, elbows, wrists** | **Right \_\_\_\_\_\_****Left \_\_\_\_\_\_*** Normal
 | * Limited range of motion: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Contracture \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Joint hypermobility
 |
| **Lower extremities****Hips, legs,****knees, ankles, feet** | **Right \_\_\_\_\_\_****Left \_\_\_\_\_\_*** Normal
* Unable to assess
 |  |
| * Limited range of motion
* Contracture
* Joint hypermobility
* Pain
 |  * Genu valgus: severe or asymmetric
* Genu varus: severe or asymmetric
 | * Metatarsus adductus
* Pes Cavus
* Vertical talus
* Clubfoot
 |
| **Neuromotor Exam** |
| **Cranial nerves** **VII, XI, XII** (other CN under eyes)* Normal
 | * Asymmetric facial movements. O. At rest. O Smile, crying
* Asymmetric turn of head
* Tongue deviation
* Difficulty with palate elevation
 |
| **Motor**  * Normal
 |   |
|  | Right Upper Extremity | Left Upper Extremity | Right Lower Extremity | Left Lower Extremity |
| Muscle bulk | O low | O low | O low | O low |
| Muscle tone | O lowO high | O lowO high | O lowO high | O lowO high |
| Strength | /5 | /5 | /5 | /5 |
| Pronator Drift | O right upper extremity | O left upper extremity |
| **Reflexes*** Normal
 | Biceps | * normal
 | * 0
 | * 1+
 | * 3+
 |
| Patellar | * normal
 | * 0
 | * 1+
 | * 3+
 |
| **Movement & Coordination** | * Normal
* Unable to assess
 |  |
| * Ataxia
* Abnormal movements

(chorea, athetosis, dystonia) | * Abnormal finger to nose test
 |
| **Dermatological** |
| **Skin*** Normal
 |  |
| * Atypical bruising/ petechiae
* Abrasions, ulcers, callouses, scars
* Rash, macule, papule
 | * Hyperpigmented lesions
* Hypopigmented lesions
 |
| **Nails*** Normal
 | * Clubbing
* Pale & spoon-shaped
 | **Hair*** Normal
 | * Patchy hair loss with broken hairs
* Thinning hair or hair loss with smooth scalp
 |

**Additional exam details (free text)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| What is the one need/concern that you would like to be addressed today?What is the one need/concern that you feel, if addressed first, would have the greatest impact on your child’s/family’s quality of life? |

**IMPRESSIONS & PLAN**

**Name of Child:**

**Name of Impressions & Plan Volunteer:**

|  |  |
| --- | --- |
| **Needs/ Concerns/ Suspected Health Conditions****(check all that apply)** | **Recommendations: Action Plan** |
| **Education/ Resources/ Counseling** | **Referrals*** **Emergent**
* **Urgent**
* **Routine**
 |
| **GENERAL HEALTH SUPERVISION*** General health supervision/ preventive care
* Under-vaccination
 | * Yes
* No
 | * Medical home
* To PCP for vaccination
 |
| **ENVIRONMENT/SOCIAL SERVICES*** Food insecurity
* Housing insecurity
* Utilities support
* Lead exposure
* Transportation
* Lacking/Inadequate Health insurance
* Victim of bullying
 | * Yes
* No
 | * Food assistance
* Housing assistance
* Utilities assistance
* Transportation assistance
* Lead screening (PCP)
* Health insurance
* Social worker
 |
| **BEHAVIOR/EMOTION** * Evaluation for Autism
* Evaluation for ADHD
* Other suspected behavioral/mood challenges
 | * Yes
* No
 | * Behavioral therapy (Applied behavioral analysis (ABA)
* Early Intervention program
* Developmental Behavioral Pediatrician
* PCP
 |
| **EDUCATION** * Needs services
* Existing services inadequate
 | * Yes
* No
 | * Education psychologist
* Neuropsychological/ psychoeducational testing
 |
| **DEVELOPMENT*** Speech/ language/ communication delay
* Fine motor delay
* Gross motor delay
* Cognitive/ problem-solving delay
* Social-emotional delay
* Global developmental delay
* Adaptive skills delay
 | * Yes
* No
 | * Developmental behavioral pediatrician
* Neurology
* PCP
* Physical therapy
* Occupational therapy
* Speech/ language therapy
* Developmental psychologist/ early childhood specialist
* Young Athletes
 |
| **NUTRITION/ GASTROINTESTINAL*** Overweight/ obesity
* Underweight/Failure to thrive
* Bowel movement disorders (constipation/diarrhea)
* Restrictive diet/Picky eating
 | * Yes
* No

  | * Gastroenterology
* Dietitian/ nutrition counseling
* PCP
 |
| **SLEEP*** Sleep problems/sleep disorders
* Obstructive sleep apnea
 | * Yes
* No
 | * Ears, Nose Throat (ENT)
* PCP for further evaluation
 |
| **VISION*** Decreased visual acuity
* Strabismus/ amblyopia
* Blindness
 | * Yes
* No
 | * Ophthalmology
* Optometry
* Opening Eyes
 |
| **HEARING*** External/middle ear infection
* Wax/cerumen impaction
* Suspected hearing impairment/loss
 | * Yes
* No
 | * Medical treatment (PCP)
* Audiology
* Healthy Hearing
 |
| **DENTAL*** *Risk* for Early Childhood Caries (ECC)
* Dental cavities/gum infections identified
* Dental preventive care
 | * Yes
* No
 | * Dentist
* Special Smiles
 |
| **ENDOCRINE*** Hyper/hypothyroidism
* Diabetes
 | * Yes
* No
 | * Endocrine referral
* PCP
 |
| **CARDIOVASCULAR*** cardiac disease/murmur
* High blood pressure
 | * Yes
* No
 | * Cardiology
* PCP
 |
| **PULMONARY*** Asthma/ chronic lung disease
* Signs of pulmonary hypertension
 | * Yes
* No
 | * Pulmonology
* Cardiology
* PCP
 |
| **MUSCULOSKELETAL*** Scoliosis/lordosis/kyphosis
* Joint contracture \_\_\_\_\_\_\_\_
* Congenital foot deformity \_\_\_
 | * Yes
* No
 | * Orthopedics
* Physical therapy
* PCP
 |
| **NEUROLOGICAL*** Suspected Increased intracranial pressure
* Seizures/ epilepsy
 | * Yes
* No
 | * Neurology
* PCP
 |
| * **PARENTAL DEPRESSION**
 |  | * Mental health professional
 |
| Other (free text):  |  |  |

|  |
| --- |
| **Referral Details** |
|  |

|  |
| --- |
| **Other** |
| * Emergency care referral: detail
 |
| * Emergency care rendered: detail
 |
| * Child abuse reporting by state/ federal law: detail
 |