Wellness Passport for Indiana's Kids

This health record belongs to:

Sunny Start
Healthy Bodies
Healthy Minds

Wellness Passport for Indiana's Kids

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How to use your Wellness Passport

- Fill in the Wellness Passport using a computer. You may also print the pages to keep in a notebook.
- Take your Wellness Passport with you each time your child sees a health care provider. Ask the provider to update the Wellness Passport.
- Keep your Wellness Passport in a handy but safe place. You may need it in a health emergency.

Program Numbers

Phone numbers for programs that provide services and/or financial assistance to eligible families at little or no cost. Find your local numbers in the phone book, online, or ask your health care provider.

State Social Security Office ( ) _____

Hoosier Healthwise ( ) _____

First Steps ( ) _____

Children's Special Health Care Services ( ) _____

Women, Infants & Children ( ) _____

Healthy Families ( ) _____

Insurance Name _____

Insurance ID Number _____

Insurance Company's Phone ( ) _____

Emergency Contact Information

How to reach the child's parent/guardian in an emergency:

Name _____

Location (work/other) _____

Address _____

Phone _____

In case of emergency, phone numbers to keep handy:

Police _____ Fire _____

Ambulance _____ Poison Control _____

Hospital _____ (Phone) _____

Doctor _____

(Phone) _____ (Fax) _____

(Address) _____

Doctor _____

(Phone) _____ (Fax) _____

(Address) _____

Doctor _____

(Phone) _____ (Fax) _____

(Address) _____

Dentist _____ (Phone) _____

Other _____ (Phone) _____

In case of emergency, health information you need to know:

Allergies (food) _____

Allergies (medicine) _____

Special Health Conditions _____

_____

Please refer to the Special Needs Addendum (a separate document) for more information.

Current Medications:

Medicine Name _____ Dosage _____

Medicine Name _____ Dosage _____

Medicine Name _____ Dosage _____

Medicine Name _____ Dosage _____

Child Information

Place Color Photo Here

Close-up of your child's face

Child's Name _____
(first)

_____
(middle) (last)

Child's Nickname _____

Birth Date _____/_____/_____
(month) (day) (year)

Sex _____

Height _____ Date _____

Weight _____ Date _____

Date of Picture _____

Parent/Caregiver _____
(first name) (last name)

Home Address _____

Phone _(_____)_____

Names of Brothers and Sisters _____

_____

_____

Child's Preferred Language _____

Child's Ethnicity/Race _____

Family's Preferred Language _____

Family's religion and/or customs that may affect medical treatment or health care

_____

_____

Other ways of communicating (sign, use of equipment, TTY, etc.) _____

_____

Do specific words or gestures have special meanings? _____

_____

_____

Birth Information

Hospital _____

City _____ State _____

Weight _____ Length _____ Apgar Score _____

Gestational Age _____ Blood Type _____

Complications at birth: _____

Family Health History

Birth Mother's Health

Check all that apply

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Smoker
- ☐ Illegal Drug Use
- ☐ Kidney Problems
- ☐ Asthma
- ☐ Epilepsy, Seizures
- ☐ Birth Defects*
- ☐ Deaf/Hard of Hearing*
- ☐ Death UNDER 50 years of age*
- ☐ Other*
- ☐ Unknown
- ☐ Heart Attack UNDER 60 years of age
- ☐ Positive TB Skin Test
- ☐ Stroke
- ☐ Alcohol Use/Abuse
- ☐ Stomach/Intestinal
- ☐ Cognitive/Developmental Delay
- ☐ Mental Health*
- ☐ Blood Disease:
  - ☐ Anemia ☐ Sickle Cell
- ☐ Allergies
- ☐ Bone/Joint Problems

*Please explain: _____

_____

Birth Father's Health

Check all that apply

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Smoker
- ☐ Illegal Drug Use
- ☐ Kidney Problems
- ☐ Asthma
- ☐ Epilepsy, Seizures
- ☐ Birth Defects*
- ☐ Deaf/Hard of Hearing*
- ☐ Death UNDER 50 years of age*
- ☐ Other*
- ☐ Unknown
- ☐ Heart Attack UNDER 60 years of age
- ☐ Positive TB Skin Test
- ☐ Stroke
- ☐ Alcohol Use/Abuse
- ☐ Stomach/Intestinal
- ☐ Cognitive/Developmental Delay
- ☐ Mental Health*
- ☐ Blood Disease:
  - ☐ Anemia ☐ Sickle Cell
- ☐ Allergies
- ☐ Bone/Joint Problems

*Please explain: _____

_____

Schedule of Regular Health Checkups & Age and Growth Chart

Baby Well Child Visits to the Doctor (% = percentile)

1 week: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

1 month: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

2 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

4 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

6 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

9 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____

Early Childhood Well Child Visits (% = percentile)

First dental visits should occur by the child's 1st birthday. Regular dental visits should be twice a year.

12 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

15 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

18 months: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

2 years: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

3 years: Height _____ % _____ Weight _____ % _____
Date _____ Head Circumference _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

4 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

Middle Childhood Well Child Visits (% = percentile)

5 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

6 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

8 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

10 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

Adolescent Health Visits (% = percentile)

11 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

12 years: Height _____ % _____ Weight _____ % _____
Date _____ Body Mass Index _____ % _____
Note: _____
Dental Visits: Date _____ Date _____ Note: _____

13 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

14 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

15 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

16 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

17 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

18 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

19 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

20 years: Height _____ % _____ Weight _____ % _____

Date _____ Body Mass Index _____ % _____

Note: _____

Dental Visits: Date _____ Date _____ Note: _____

Additional Doctor & Dental Visits, Hospitalizations and/or Record of Illnesses

(Include annual gynecological visits for females here when appropriate.)

Date	Health Care Provider	Reason for visit or describe illness

Date	Health Care Provider	Reason for visit or describe illness

Date	Health Care Provider	Reason for visit or describe illness

Immunization Chart

- Immunizations are vaccines given by shot or by mouth that help prevent certain diseases.
- Immunize your children to help keep them healthy.
- The following chart shows you what your child needs at what age. Keep track of the immunizations on page 13-14.
- If you find that your child has missed any vaccines, it is not necessary to start over. Check with your health care provider to complete the needed immunizations.
- Your health care provider will fill in the record when vaccines are given. Some states require their own record keeping card. In that case, keep it with your child's Wellness Passport and bring both to every routine or emergency health care visit.

The Immunization Chart on page 12 is adapted from *The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years and ~Aged 7 Through 18 Years, United States 2009*, approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians.

For the latest Immunization Schedule, please visit
http://www.cdc.gov/vaccines/recs/schedules

Vaccine▼ Age▶	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-18 yrs
Hepatitis B	HepB	HepB			HepB							HepB Series*		
Rotavirus			RV	RV	RV*									
Diphtheria, Tetanus, Pertusis			DTaP	DTaP	DTaP	DTaP					DTaP		Tdap	Tdap*
Haemophilus influenzae type b			Hib	Hib	Hib	Hib								
Pneumococcal			PCV	PCV	PCV	PCV				PPSV certain high-risk groups				
Inactivated Poliovirus			IPV	IPV	IPV						IPV	IPV*		
Influenza					Influenza (Yearly)									
Measles, Mumps, Rubella						MMR					MMR	MMR*		
Varicella						Varicella					Varicella	Varicella Series*		
Hepatitis A							HepA (2 doses)			HepA Series certain high-risk groups				
Meningococcal										MCV certain high-risk groups			MCV	MCV*
Human Papillomavirus												HPV min age 9	HPV 3 doses	HPV*

Shaded areas indicate range of recommended ages. *=If needed. Times for certain high-risk groups are noted.

Immunization Record

Health Care Providers will assist in completing these pages.
Future new and combination vaccines will change the schedule.

Vaccine		Brand	Date (m/d/y)	Provider Signature	Date Next Due
Diphtheria, Tetanus, Pertussis (DTaP/DT)	1				
	2				
	3				
	4				
	5				
Tetanus Diphtheria (Td)	1				
	2				
	3				
Tdap	1				
Polio (IPV or OPV)	1				
	2				
	3				
	4				
Measles, Mumps Rubella (MMR)	1				
	2				
Haemophilus Influenzae b (Hib)	1				
	2				
	3				
	4				
Pneumococcal Conjugate (PVC 7)	1				
	2				
	3				
	4				
Hepatitis B	1				
	2				
	3				
Hepatitis A	1				
	2				
Varicella	1				
	2				

Child's Name _____

Birth Date _____

Vaccine		Brand	Date (m/d/y)	Provider Signature	Date Next Due
Rotavirus	1				
	2				
	3				
Tuberculin Skin Test	1				
	2				
Human Papillomavirus (HPV)	1				
	2				
	3				
Meningococcal	1				
Influenza (yearly)					
Other Immunizations					

Growth of Body and Mind

Record your child's development here. The age listed is the time when most children are doing these things. Each child is different; if your child is not doing one activity at the age listed, there is no need to worry. If your child is late in doing several activities, talk it over with your health care provider. Children born early need extra time to catch up. For example, a 2-month-old baby who was born one month early can be compared to a 1-month-old term baby. Catching up goes on until about age 2 years. In the spaces below, record the age when you first notice your child doing the following:

	Age
1 Month	
• Moves arms and legs at the same time	_____
• Raises head when lying on tummy	_____
• Jumps at loud noises or sudden movements	_____
• Watches your face when it's close	_____
2 Months	
• Turns head from side to side when lying on tummy	_____
• Watches and follows briefly with eyes	_____
• Smiles when talked to	_____
3 Months	
• Holds head up	_____
• Lifts head and chest when lying on tummy	_____
• Holds hands together	_____
• Squeals	_____
4 Months	
• Rolls from back to tummy	_____
• Follows objects with eyes	_____
• Grasps objects; plays with hands	_____
• Turns head toward sounds	_____
5 Months	
• Stretches out arms to be picked up	_____
• Knows familiar faces and voices	_____
• Reaches for objects	_____
• Makes sounds to get attention	_____
6 Months	
• Raises body up on hands	_____
• Sits with support; rolls over	_____
• Begins finger feeding	_____
• Copies sounds made by others; babbles and laughs	_____

7 Months — Age

- Moves object from one hand to the other . . . . . _____
- Points and smiles at image in mirror. . . . . _____
- Knows parents and caregivers . . . . . _____

8 Months

- Sits well alone. . . . . _____
- Stands for a short time holding on for support . . . . . _____
- Creeps (pulling body with arms and leg kicks) . . . . . _____

9 Months

- Crawls (on hands and knees). . . . . _____
- Picks up objects with thumb and finger . . . . . _____
- Makes two same sounds like "ba-ba" or "ga-ga". . . . . _____
- Responds to name . . . . . _____
- May cry with strangers . . . . . _____

10 Months

- Hits together two objects held in hand. . . . . _____
- Plays pat-a-cake and peek-a-boo. . . . . _____
- Knows simple words, "no" "bye-bye" . . . . . _____
- Looks for hidden objects . . . . . _____

11 Months

- Says "ma-ma" or "da-da" . . . . . _____
- Walks holding onto the side of the crib or playpen . . . . . _____
- Stands alone briefly . . . . . _____
- Waves "bye-bye" . . . . . _____

12 Months

- Stands alone well; walks with support. . . . . _____
- Says two words besides "ma-ma", "da-da" . . . . . _____
- Feeds self with spoon or fingers . . . . . _____
- Follows simple commands and copies others. . . . . _____

15 Months

- Walks well; helps with dressing . . . . . _____
- Gives and takes toys . . . . . _____
- Says 5 to 15 single words . . . . . _____
- Drinks from a cup held in both hands . . . . . _____
- Listens to stories; points to pictures. . . . . _____
- Stacks 2 blocks; scribbles with crayons . . . . . _____

18 Months — Age

- Walks up stairs with hand held . . . . . _____
- Eats with spoon and fork . . . . . _____
- Plays at pretend games. . . . . _____
- Points to body parts . . . . . _____
- Likes to play with other children . . . . . _____

2 Years

- Runs; jumps; throws ball. . . . . _____
- Puts on clothes; washes hands with help . . . . . _____
- Says 50 words; uses 2 or 3 word sentences . . . . . _____
- Calls self by name; asks for "more" . . . . . _____
- Opens a door . . . . . _____
- Remembers where objects are hidden . . . . . _____
- Begins toilet training . . . . . _____

3 Years

- Kicks ball; walks up stairs . . . . . _____
- Stacks 8 blocks. . . . . _____
- Uses 3- to 4-word sentences . . . . . _____
- Knows full name and sex . . . . . _____
- Dresses self except for buttons. . . . . _____
- Toilet training in progress . . . . . _____
- Plays in small groups . . . . . _____

4 Years

- Hops and stands on 1 foot; catches a ball . . . . . _____
- May have make-believe friends . . . . . _____
- Uses at least 6-word sentences; asks questions . . . . . _____
- Washes hands and brushes teeth without help . . . . . _____
- Copies a circle and a cross. . . . . _____
- Toilet trained. . . . . _____
- Can share; wait her turn. . . . . _____

5 Years

- Skips; stands on 1 foot for 60 seconds . . . . . _____
- Tells a simple story using full sentences . . . . . _____
- Listens; follows simple directions. . . . . _____
- Counts to 10; knows 4 colors and own age. . . . . _____
- Copies a square; prints some letters and numbers . . . . . _____

Medical Visit Checklist

A timeline guide for recommended procedures and screenings.

	Infancy								Early Childhood				
Age	New-born	1-2wk	1m	2m	4m	6m	9m	12m	15m	18m	2y	3y	4y
History & Physical Examination													
Measurements:													
Height & Weight													
Head Circumference												•	•
Blood Pressure	•	•	•	•	•	•	•	•	•	•	•		
Sensory Screening													
Vision													
Hearing													
Developmental/ Behavioral Screening													
General Procedures													
Hereditary/Metabolic Screening				•	•	•	•	•	•	•	•	•	•
Lead Screening	•	•	•	•	•	•							
Hematocrit or Hemoglobin													
Professional Dental Exam	•	•	•	•	•	•	•	•					
Mantoux Tuberculin Skin Test	•	•	•	•	•	•	•						
Cholesterol Screening	•	•	•	•	•	•	•	•	•	•			

Key: EMPTY BOX = Recommended at this age • = NOT recommended at this age ▢ = To be performed on patients AT RISK

Medical Visit Checklist

A timeline guide for recommended procedures and screenings.

	Middle Childhood						Adolescence									
Age	5y	6y	7y	8y	9y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y
History & Physical Examination																
Measurements:																
Height & Weight																
Blood Pressure																
Sensory Screening																
Vision																
Hearing																
Developmental/ Behavioral Screening																
General Procedures																
Lead Screening			•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin																
Urinalysis																
Professional Dental Exam																
At-Risk Patient Procedures																
Mantoux Tuberculin Skin Test																
Cholesterol Screening																
GC, Chlamydia, Syphilis, HPV, HIV	•	•	•	•	•	•										
Pelvic Exam and Pap Smear	•	•	•	•	•	•										

Key: EMPTY BOX = Recommended at this age • = NOT recommended at this age ☐ = To be performed on patients AT RISK

Safety Checklist

Is your home smoke-free?	❑ Yes	❑ No
Working smoke detectors in home?	❑ Yes	❑ No
Child placed in car or booster seat in back seat?	❑ Yes	❑ No
Child uses seat belt in vehicle?	❑ Yes	❑ No
Do you keep any guns in your home?	❑ Yes	❑ No

If you answered Yes, please complete the next two questions.
If you answered No, skip the next two questions.

Do you keep the guns locked and out of reach of children?	❑ Yes	❑ No
Do you keep the ammunition locked and in a different location than the guns?	❑ Yes	❑ No
Child placed in a safe crib - slats 2-3/8" apart or less?	❑ Yes	❑ No
Baby placed on back to sleep?	❑ Yes	❑ No
Household medicines and poisons out of reach of children?	❑ Yes	❑ No
Is child always watched by an adult while in the tub?	❑ Yes	❑ No
Is your home's hot water adjusted to a safe temperature (120° or less)?	❑ Yes	❑ No
Are electrical cords beyond your child's reach?	❑ Yes	❑ No
Do you have plastic outlet plugs in all unused electrical outlets?	❑ Yes	❑ No
Do you always watch your infant while he/she is on a high surface (i.e., changing table)?	❑ Yes	❑ No
Do you keep small items and foods that can choke your child out of his/her reach?	❑ Yes	❑ No
Was your home built after 1978?	❑ Yes	❑ No
Has anyone (friends or family) been tested positive for lead?	❑ Yes	❑ No

For more information on safety tips for your child, please see the Early Childhood Meeting Place –
http://earlychildhoodmeetingplace.indiana.edu
or ask your health care provider.

Information to take to the doctor

Your Questions:

Be prepared . . . ask . . . write . . . visit.

Be ready to tell the doctor:

How your child is doing . . .

- What things have been like
- Successes and setbacks
- Describe a typical day

Signs or problems you are worried about:

- What they are
- When they started
- How often and when they happen

Medications being used:

The doctor must know all drugs currently being used, including over the counter drugs, in order to prescribe effectively. Bring a list of over the counter and prescription medications with you to the appointment.

Allergies and Reactions:

The doctor must be told of any reactions your child has experienced from any medications.

Information to get from the doctor

Make sure you ask for:

Instruction for medication(s):

- The medication name(s)
- How long they should be given
- What the side effects are
- What the child should be eating

Instructions for treatment/therapy(s):

- The name • What for? • How often? • For how long?

Are follow-up visits needed?

- With whom? • For what? • How soon? • Do I need a referral?
- Who do I contact if I have questions before my next appointment?

The Social Security Card

Social Security No._____

You may have been given a social security number for your child when you filed for his/her birth certificate. If not, you may contact any Social Security office or call 1-800-772-1213 to get one.

Your child needs a social security number when you:

- Claim him/her as a dependent on your income tax
- Open a bank account, buy savings bonds, or apply for services for your child
- Apply for public or private health insurance.

When your child is older, he/she will need a social security number to:

- Go to work when he/she is old enough
- Apply for a driver's license.

If you lose the card, the Social Security Administration will replace it at no charge. Your child will always be given the same social security number and it will follow her throughout life. You will need proof of your child's ID.

Your Child's Fingerprints

Should something happen to your child, fingerprints can help identify a child because each person's fingerprints are unique. Fingerprints are of no value unless they are mature and taken the right way. **Your child's fingerprints don't mature until 30 to 36 months of age.**

Only trained people such as police or security officers should take your child's fingerprints.

L. Index	L. Thumb	R. Thumb	R. Index

For More Information

Visit the Early Childhood Meeting Place website:

http://earlychildhoodmeetingplace.indiana.edu

In the **Family Info & Resources** section, you can click your county on the Indiana map to find local, county, and state programs, resources and services in the following groupings:

- Community Resources
- Child Care and Early Education
- Health and Safety
- Parenting and Families
- Financial Resources Fact Sheets

The Parenting and Families section features *A Parent's Guide to Raising Healthy, Happy Babies,* a developmental calendar in English or Spanish, which you can download, print, and enter your child's growth and development from birth through 5 years.

The Health and Safety section includes a link to a downloadable copy of this medical passport.

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Copies may be requested by calling
the Indiana Family Helpline:
1-800-433-0746