YOUR CHILD’S CHECKUPS

Regular well-child and oral health checkups are very important for your child’s health and development. This Childhood Health Record, along with the Lifetime Immunization Record, will help you keep track of important health information about your child.

Keep each section up to date so you’ll have a useful and handy record of your child’s health history. These records provide valuable information in an emergency and throughout your child’s life. Keep them in a safe place at home and take them with you when you travel.

PREPARE FOR WELL-CHILD CHECKUPS

You will receive letters in the mail from the Department of Health with reminders to schedule checkups. They will also give you information about your child’s growth and development, safety, nutrition, and recommended immunizations. Before each checkup, write down any questions you have about your child’s health and development and take them with you. Be sure to ask if your child’s immunizations are up-to-date.

Take this booklet and the Immunization Record to your child’s medical and dental visits. You can also access your child’s immunization records online at https://wa.myir.net/.
BIRTH RECORD

Name___________________________________________________________

Date of Birth___ / ____ / ____  Time___________________________

Weight_____lb._____oz.   Length______________________________

Place of Birth________________________________________________

City/State_____________________________________________________

Notes________________________________________________________

_________________________________________________________________

_________________________________________________________________

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_________________________________________________________________
EMERGENCY INFORMATION

In an emergency, call 911
Washington Poison Center: 1-800-222-1222
Other important contacts____________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Allergies/Treatments_______________________________
_______________________________________________
_______________________________________________
_______________________________________________

Special Health Needs/Treatments____________________
_______________________________________________
_______________________________________________
_______________________________________________
HEALTH SCREENINGS

Health screenings are used to find or rule out certain health conditions. All children get certain screenings, such as hearing and vision checks. Some children will need other screenings, such as anemia or lead level testing. Talk to your child’s doctor or nurse at each well-child checkup to learn more about the screenings your child needs.

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<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Results</th>
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HEALTH CHECKUPS

H = height  H% = height percentile  W = weight
W% = weight percentile  HC = head circumference
BMI = body mass index  BMI% = BMI percentile

1-2 weeks

Health Checkup
Date___________
Doctor/Clinic_________________________
Address/Phone________________________________
H________H%_______W_______W%_______HC_______
Notes__________________________________________
Injuries/Illnesses________________________________

1 month

Health Checkup
Date___________
Doctor/Clinic_________________________
Address/Phone________________________________
H________H%_______W_______W%_______HC_______
Notes__________________________________________
Injuries/Illnesses________________________________
Health Checkup

Date_____________
Doctor/Clinic_______________________

Address/Phone________________________________

H________H%_______W_______W%_______HC_______

Notes__________________________________________

_______________________________________________

Injuries/Illnesses_________________________________

_______________________________________________

Health Checkup

Date_____________
Doctor/Clinic_______________________

Address/Phone________________________________

H________H%_______W_______W%_______HC_______

Notes__________________________________________

_______________________________________________

Injuries/Illnesses_________________________________

_______________________________________________

2 months

4 months
6 months

Health Checkup
Date___________
Doctor/Clinic____________________________________
Address/Phone____________________________________
H________H%_______W_______W%_______HC_______
Notes____________________________________________
__________________________________________________
Injuries/Illnesses__________________________________
__________________________________________________

9 months

Health Checkup
Date___________
Doctor/Clinic____________________________________
Address/Phone____________________________________
H________H%_______W_______W%_______HC_______
Notes____________________________________________
__________________________________________________
Injuries/Illnesses__________________________________
__________________________________________________
The first oral health checkup is recommended by one year of age or within six months of the first tooth erupting. Talk to your dentist about preventing cavities with flouride and sealants.
Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________
H________H%_______W_______W%_______HC_______
Notes__________________________________________
_______________________________________________
Injuries/Illnesses_________________________________
_______________________________________________

15 months

Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________
H________H%_______W_______W%_______HC_______
Notes__________________________________________
_______________________________________________
Injuries/Illnesses_________________________________
_______________________________________________

18 months

Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________
H________H%_______W_______W%_______HC_______
Notes__________________________________________
_______________________________________________
Injuries/Illnesses_________________________________
_______________________________________________
The two-year visit is a good time to be sure your child has had all recommended immunizations. Ask your doctor, nurse, or clinic about any immunizations your child may have missed. Some doctors will want to schedule a checkup at 2½ years. This is a good time to talk about any development questions you have about your child. Ask your doctor or clinic if you should schedule a checkup at 2½ years.

### Health Checkup

<table>
<thead>
<tr>
<th>Date</th>
<th>Doctor/Clinic</th>
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<tbody>
<tr>
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<td>Address/Phone</td>
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<tr>
<td>H______W______HC_______BMI_______BMI%_______</td>
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<td>Notes</td>
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<td>Injuries/Illnesses</td>
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### Oral Health Checkup

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<th>Dentist/Clinic</th>
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<td>Address/Phone</td>
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<tr>
<td>Services Received</td>
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<td>Notes</td>
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</tbody>
</table>
Health Checkup

Date___________

Doctor/Clinic________________________

Address/Phone__________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

Injuries/Illnesses_________________________________

__________________________________________________________________________

Oral Health Checkup

Date__________________

Dentist/Clinic____________________________________

Address/Phone__________________________________

Services Received_________________________________

__________________________________________________________________________

Notes__________________________________________

__________________________________________________________________________
Health Checkup

Date___________

Doctor/Clinic________________________________

Address/Phone__________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

Injuries/Illnesses________________________________

_______________________________________________

Oral Health Checkup

Date__________________

Dentist/Clinic____________________________________

Address/Phone__________________________________

Services Received________________________________

______________________________________________________________________________

Notes__________________________________________

______________________________________________________________________________
Children immunized according to the recommended schedule will meet school entry requirements. You will need to provide a copy of your child’s immunization record. Talk to your doctor, nurse, or clinic for more information. You can also access your family’s immunization information online. Go to http://wa.myir.net.

**Health Checkup**  Date______________

Doctor/Clinic____________________________________

Address/Phone____________________________________

H_________W_________BMI_________BMI%_________

Notes_____________________________________________

____________________________________________________________________________________

Injuries/Illnesses_____________________________________

____________________________________________________________________________________

**Oral Health Checkup**  Date______________

Dentist/Clinic____________________________________

Address/Phone____________________________________

Services Received__________________________________

____________________________________________________________________________________

Notes_____________________________________________

____________________________________________________________________________________
Health Checkup

Date

Doctor/Clinic

Address/Phone

H_________W_________BMI_________BMI%_________

Notes__________________________________________

_______________________________________________

Injuries/Illnesses_________________________________

_______________________________________________

_______________________________________________

Oral Health Checkup

Date

Dentist/Clinic

Address/Phone

Services Received________________________________

________________________________________________________________________________________

Notes__________________________________________

________________________________________________________________________________________
Health Checkup

Date___________
Doctor/Clinic____________________________________
Address/Phone____________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

__________________________________________________________________________

Injuries/Illnesses_________________________________

__________________________________________________________________________

__________________________________________________________________________

Oral Health Checkup

Date__________________

Dentist/Clinic____________________________________
Address/Phone____________________________________

Services Received________________________________

__________________________________________________________________________

Notes__________________________________________

__________________________________________________________________________

__________________________________________________________________________
Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________
H_________W_________BMI_________BMI%__________
Notes__________________________________________

Injuries/Illnesses_________________________________

_______________________________________________

Oral Health Checkup

Date__________________
Dentist/Clinic____________________________________
Address/Phone__________________________________
Services Received________________________________

Notes__________________________________________

_______________________________________________

8 years
Health Checkup

Date__________________

Doctor/Clinic________________________

Address/Phone__________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

Injuries/Illnesses________________________________

Oral Health Checkup

Date__________________

Dentist/Clinic____________________________________

Address/Phone__________________________________

Services Received________________________________

Notes__________________________________________
Health Checkup

Date___________
Doctor/Clinic________________________

Address/Phone__________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

_______________________________________________

Injuries/Illnesses_________________________________

_______________________________________________

_______________________________________________

Oral Health Checkup

Date__________________

Dentist/Clinic____________________________________

Address/Phone__________________________________

Services Received________________________________

_______________________________________________

Notes__________________________________________

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_______________________________________________
There are several immunizations recommended for your child at 11 to 12 years of age. Schedule a health checkup for your child at this age. You can also ask about immunizations at a sports physical or other doctor visit.

**Health Checkup**

Date____________________

Doctor/Clinic____________________________________________________

Address/Phone____________________________________________________

H_______W_______BMI_______BMI%_________

Notes__________________________________________

Injuries/Illnesses__________________________________________

_______________________________________________

**Oral Health Checkup**

Date____________________

Dentist/Clinic____________________________________________________

Address/Phone____________________________________________________

Services Received____________________________________________________

_______________________________________________

Notes____________________________________________________
Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________
H_________W_________BMI_________BMI%___________
Notes__________________________________________

__________________________________________________________________

Injuries/Illnesses_________________________________
__________________________________________________________________

__________________________________________________________________

Oral Health Checkup    Date__________________

Dentist/Clinic____________________________________
Address/Phone__________________________________
Services Received________________________________
__________________________________________________________________

Notes__________________________________________
__________________________________________________________________

__________________________________________________________________
Health Checkup

Date____________
Doctor/Clinic____________________________

Address/Phone________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

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Injuries/Illnesses_________________________________

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_______________________________________________

Oral Health Checkup

Date____________

Dentist/Clinic____________________________________

Address/Phone____________________________________

Services Received________________________________

_______________________________________________

Notes__________________________________________

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_______________________________________________
Health Checkup

Date___________
Doctor/Clinic________________________
Address/Phone__________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

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Injuries/Illnesses_________________________________

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Oral Health Checkup

Date__________________
Dentist/Clinic____________________________________
Address/Phone__________________________________

Services Received________________________________

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Notes__________________________________________

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_______________________________________________
Health Checkup

Date________________
Doctor/Clinic_____________________
Address/Phone__________________________________
H_________W_________BMI_________BMI%_________
Notes__________________________________________

Injuries/Illnesses_________________________________

Oral Health Checkup

Date________________
Dentist/Clinic____________________________________
Address/Phone__________________________________
Services Received________________________________

Notes__________________________________________

15 years
Health Checkup

Date___________
Doctor/Clinic________________________________
Address/Phone________________________________
H_________W_________BMI_________BMI%_________
Notes__________________________________________

Injuries/Illnesses________________________________

Oral Health Checkup

Date________________
Dentist/Clinic____________________________________
Address/Phone__________________________________
Services Received________________________________

Notes__________________________________________

16 years
If your child has had all recommended immunizations, he or she will meet immunization requirements for college, the military, and future employment. Be sure to ask about additional travel immunizations your child may need.

**Health Checkup**

Date

Doctor/Clinic

Address/Phone

H________W________BMI________BMI%________

Notes

Injuries/Illnesses

**Oral Health Checkup**

Date

Dentist/Clinic

Address/Phone

Services Received

Notes
Now that your child is 18, he or she can sign up for MyIR to get access to his or her immunization records online. Visit https://wa.myir.net.

**Health Checkup**

Date__________

Doctor/Clinic____________________________________

Address/Phone____________________________________

H_________W_________BMI_________BMI%__________

Notes__________________________________________

Injuries/Illnesses_________________________________


**Oral Health Checkup**

Date________________

Dentist/Clinic____________________________________

Address/Phone____________________________________

Services Received________________________________

Notes__________________________________________

_______________________________________________