PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
18 MONTH VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. **Child Development and Autism Spectrum Disorder screenings are also part of this visit.** Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your child is able to do.

- ☐ Engage with others for play.
- ☐ Help dress and undress himself.
- ☐ Point to pictures in a book.
- ☐ Point to an interesting object to draw your attention to it.
- ☐ Turn and look at an adult if something new happens.
- ☐ Begin to scoop with a spoon.
- ☐ Use words to ask for help.
- ☐ Identify at least 2 body parts.
- ☐ Name at least 5 familiar objects, such as ball or milk.
- ☐ Walk up with 2 feet per step with his hand held.
- ☐ Sit in a small chair.
- ☐ Carry a toy while walking.
- ☐ Scribble spontaneously.
- ☐ Throw a small ball a few feet while standing.

PATIENT NAME: _____ DATE: _____

Please print.

18 MONTH VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR CHILD'S BEHAVIOR

Do you praise your child for good behavior?		O Yes	O No
If your child is upset, do you help distract him with another activity, book, or toy?		O Yes	O No
Do other caregivers set the same limits for your child as you do?		O Yes	O No
Do you use time-outs as a way to manage your child's behavior?		O Yes	O No
Have you thought about toilet training?		O Yes	O No
If you are planning to have another baby, have you thought about how you will prepare your child?	O NA	O Yes	O No

TALKING AND COMMUNICATING

Do you read, sing, and talk with your child about what you are seeing and doing?	O Yes	O No
Does he wave "bye-bye"?	O Yes	O No
Do you use simple words to tell your child what to do?	O Yes	O No

YOUR CHILD AND TV

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
If your child uses media, do you monitor the shows your child watches or activity she does?	O Yes	O No

HEALTHY EATING

Do you provide a variety of vegetables, fruits, and other nutritious foods?	O Yes	O No
Does your child eat much food that you would describe as junk food?	O No	O Yes
Does your child drink water every day?	O Yes	O No
Is your child willing to try new foods?	O Yes	O No

SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat car every time he rides in a vehicle?	O Yes	O No
Does everyone in the car always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	O Yes	O No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

18 MONTH VISIT

SAFETY (*CONTINUED*)

Car and Home Safety (*continued*)		
Do you keep your child away from the stove, fireplaces, and space heaters?	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	O Yes	O No
Do you have any questions about other ways to keep your home safe?	O No	O Yes
Sun Protection		
Do you apply sunscreen on your child whenever she plays outside?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

Child's Name _____ Date of Birth _____ Today's Date _____

M-CHAT Autism Screen

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (i.e., you've seen it once or twice), please answer as if the child does ***not*** do it.

Questions	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?	☐	☐
2. * Does your child take an interest in other children?	☐	☐
3. Does your child like climbing on things, such as up stairs?	☐	☐
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	☐	☐
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	☐	☐
6. Does your child ever use his/her index finger to point, to ask for something?	☐	☐
7. * Does your child every use his/her index finger to point, to indicate interest in something?	☐	☐
8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them?	☐	☐
9. * Does your child ever bring objects over to you (parent) to show you something?	☐	☐
10. Does your child look you in the eye for more than a second or two?	☐	☐
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	☐	☐
12. Does your child smile in response to your face or your smile?	☐	☐
13. * Does your child imitate you? (e.g., if you make a face, will your child imitate it?)	☐	☐
14. * Does your child respond to his/her name when you call?	☐	☐
15. * If you point at a toy across the room, does your child look at it?	☐	☐
16. Does your child walk?	☐	☐
17. Does your child look at things you are looking at?	☐	☐
18. Does your child make unusual finger movements near his/her face?	☐	☐
19. Does your child try to attract your attention to his/her own activity?	☐	☐
20. Have you ever wondered if your child is deaf?	☐	☐
21. Does your child understand what people say?	☐	☐
22. Does your child sometimes stare at nothing or wander with no purpose?	☐	☐
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	☐	☐

Two or more of the asterisked (*) items, or three of any items require more evaluation or referral.

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PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

.

Parent/Guardian Name (print) Signature Date

PEDS Response Form

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

1. Please list any concerns about your child's learning, development, and behaviour.

2. Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

4. 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:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

10. Please list any other concerns.

PEDS Score Form – Authorised Australian Version

Child's Name:_____ Date of Birth:_____ Date(s) of scoring:_____

Find appropriate column for the child's age. Place a tick in the appropriate box to show each concern on the PEDS Response Form. See Brief Scoring Guide for details on categorising concerns. Shaded boxes are significant predictors of difficulties. Non-shaded boxes are non significant predictors.

Child's Age:	0-3 mos	4-5 mos	6-11 mos	12-14 mos	15-17 mos	18-23 mos	24-35 mos	36-47 mos	48-53 mos	54-71 mos	72-83 mos	84-96 mos
Global/Cognitive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expressive Language and Articulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Receptive Language	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fine Motor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gross Motor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social-emotional	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-help	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Count the number of ticks in the small shaded boxes and place the total in the large shaded box below.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the number shown in the large shaded box is 2 or more, follow **Path A** on PEDS Interpretation Form. If the number shown is exactly 1, follow **Path B**. If the number shown is 0, count the number of ticks in the small unshaded boxes and place the total in the large unshaded box below.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the number shown in the large unshaded box is 1 or more, follow **Path C**. If the number 0 is shown, consider **Path D** if relevant. Otherwise, follow **Path E**.

Child's Name:_____ Date of Birth:_____

PEDS Interpretation Form

Path A: Two or more significant predictive concerns? → Yes? → Two or more concerns about self-help, social, school, or receptive language skills?
- Yes? → Refer for audiological and speech-language testing. Use professional judgment to decide if referrals are also needed for social work, occupational/physiotherapy, mental health services, etc.
- No? → Refer for intellectual and educational assessments. Use professional judgment to decide if speech-language, audiological, or other evaluations are also needed.

Path B: One significant predictive concern? → Yes? → Screen or refer for screening.
- If screen is passed, counsel in areas of concern and monitor carefully.
- If screen is failed, refer for testing in area(s) of difficulty.

Path C: Non significant concerns? → Yes? → Counsel in areas of difficulty and follow up in several weeks. → If unsuccessful, screen for emotional/behavioural problems and refer as indicated. Otherwise refer for parent training, behavioural intervention, etc.

Path D: Parental difficulties communicating? → Yes? → Foreign language a barrier?
- No? → Use a second screen that directly elicits children's skills or refer for screening elsewhere.
- Yes? → Send PEDS home in preparation for a second visit; seek an interpreter, or refer for screening elsewhere.

Path E: No concerns? → Yes? → Elicit any concerns at future time-point? → Use PEDS at future time-point.

Specific Decisions

0–3 mos. _____

4–5 mos. _____

6–11 mos. _____

12–14 mos. _____

15–17 mos. _____

18–23 mos. _____

24–35 mos. _____

36–47 mos. _____

48–53 mos. _____

54–71 mos. _____

72–83 mos. _____

84–96 mos. _____

PROVIDER ONLY

VACCINE INFORMATION STATEMENT

Hepatitis A Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis A is a serious liver disease. It is caused by the hepatitis A virus (HAV). HAV is spread from person to person through contact with the feces (stool) of people who are infected, which can easily happen if someone does not wash his or her hands properly. You can also get hepatitis A from food, water, or objects contaminated with HAV.

Symptoms of hepatitis A can include:

- fever, fatigue, loss of appetite, nausea, vomiting, and/or joint pain
- severe stomach pains and diarrhea (mainly in children), or
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements).

These symptoms usually appear 2 to 6 weeks after exposure and usually last less than 2 months, although some people can be ill for as long as 6 months. If you have hepatitis A you may be too ill to work.

Children often do not have symptoms, but most adults do. You can spread HAV without having symptoms.

Hepatitis A can cause liver failure and death, although this is rare and occurs more commonly in persons 50 years of age or older and persons with other liver diseases, such as hepatitis B or C.

Hepatitis A vaccine can prevent hepatitis A. Hepatitis A vaccines were recommended in the United States beginning in 1996. Since then, the number of cases reported each year in the U.S. has dropped from around 31,000 cases to fewer than 1,500 cases.

2 Hepatitis A vaccine

Hepatitis A vaccine is an inactivated (killed) vaccine. You will need **2 doses** for long-lasting protection. These doses should be given at least 6 months apart.

Children are routinely vaccinated between their first and second birthdays (12 through 23 months of age). Older children and adolescents can get the vaccine after 23 months. Adults who have not been vaccinated previously and want to be protected against hepatitis A can also get the vaccine.

You should get hepatitis A vaccine if you:

- are traveling to countries where hepatitis A is common,
- are a man who has sex with other men,
- use illegal drugs,
- have a chronic liver disease such as hepatitis B or hepatitis C,
- are being treated with clotting-factor concentrates,
- work with hepatitis A-infected animals or in a hepatitis A research laboratory, or
- expect to have close personal contact with an international adoptee from a country where hepatitis A is common

Ask your healthcare provider if you want more information about any of these groups.

There are no known risks to getting hepatitis A vaccine at the same time as other vaccines.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of hepatitis A vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If you are not feeling well.** If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis A vaccine do not have any problems with it.

Minor problems following hepatitis A vaccine include:
- soreness or redness where the shot was given
- low-grade fever
- headache
- tiredness

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**