OBERLIN ROAD PEDIATRICS

Well Child Check: School Aged Child (6-10 years)

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your child take any medications or supplements, including vitamins? If yes, please list. □ No □ Yes: _____

Does your child have known allergies to foods/medicines? If yes, please list □ No □ Yes: _____

Does your child see any specialists outside of Oberlin? □ No □ Yes: _____

Dental Health:

Does your child see a dentist 1-2 times a year? □ Yes □ No

Does your water source contain fluoride? □ Yes (=city water) □ No (=well water)

Does your child brush their teeth with fluoridated toothpaste 2x a day? □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe) □ No □Yes

Nutrition:

Are they usually getting 3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

If 9 years old+, are they getting 4 servings?

What type of milk is your child drinking? □ Whole Milk □ 2% □ 1% □ other _____

Are they eating iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □ No

Who lives with your child? Please List (mother, father, siblings, grandparents, aunt, etc.)

_____

Are parents: single married divorced separated widowed

School:

Current grade/name of school? _____

Do you have concerns about your child's school performance? □ No □ Yes _____

Does your child receive any special education services? □ No □ Yes

What interests/activities does your child have? Where does your child excel?

_____

_____

Has your child ever bullied or been bullied? □ No □ Yes

Does your child usually seem happy? □ Yes □ No

Does your family get along well with each other? □ Yes □ No

Does your child have chores or responsibilities? □ Yes □ No

When your child breaks the rules, are you consistent with consequences and discipline? □ Yes □ No

Do you let your child know when she is being good?	□ Yes	□ No
Does your child have problems dealing with angry or worried feelings?	No	Yes
Do you have any concerns about your child's eating? This includes enough milk, fruits and vegetables.	No	Yes
Do you offer them a variety of foods including fruits, vegetables, and proteins?	Yes	No
Do they decide how much to eat and when to stop?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes
Do they eat breakfast?	Yes	No
Is your child physically active at least 1 hour every day?	Yes	No
This includes running, playing sports or active play with friends?		
How much time does your child spend watching screens?	_____	
Do they have a screen or TV in their bedroom?	No	Yes
Do you supervise/ have rules about internet use?	Yes	No
Does your child have a regular bedtime?	Yes	No
Does your child have trouble going to sleep?	No	Yes
Is your child in a booster seat every time they ride in the car?	Yes	No
If over 4'9" and 80lbs and thus out of the booster seat, are they riding in the back seat?	Yes	No
Can your child swim?	Yes	No
Does your child wear sunscreen?	Yes	No
Does your child wear a helmet when biking, skating, or scootering?	Yes	No
Do you have smoke alarms and carbon monoxide alarms in your house?	Yes	No
Does your child spend time in a place with an unlocked gun?	No	Yes
Has your partner or another significant person in your life ever hurt you or your child?	No	Yes
Do you have the things you need to take care of your child?	Yes	No
Does your home have enough heat/AC, hot water, electricity?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out?	No	Yes
Is there anyone in your child's life whose alcohol/drug use concerns you?	No	Yes
Do you discuss with your child that no one should see their private parts or keep secrets from their parents?	Yes	No