WELL CHILD EXAM
INFANCY:
6 MONTH VISIT

Michigan Department of Human Services

Authority: P.A. 116 of 1973
Completion: Required
Consequences of non-completion:
Non-compliance of licensing rules.

Well Child Exam Date			
Patient Name	DOB	Sex	Parent Name

Allergies	Current Medications

Prenatal/Family History

Weight	Percentile %	Length	Percentile %	HC	Percentile %	Temp.	Pulse	Resp.	BP (if risk)

Birth History Birth Weight Gestation ☐ Vaginal ☐ C-Section **Complications** ☐ Yes ☐ No

Interval History:

(Include injury/illness, visits to other health care providers, changes in family or home)

Apnea ☐ Yes ☐ No ☐ Monitor

☐ Breast every _____ hours

☐ Formula _____ oz every _____ hours

With iron ☐ Yes ☐ No

Type or brand _____

☐ City Water ☐ Well Water

Solids ☐ Yes ☐ No

Elimination ☐ Normal ☐ Abnormal

Sleep

☐ Normal (6 – 8 hours) ☐ Abnormal

Additional area for comments on page 2

WIC ☐ Yes ☐ No

Maternal Infant Health Program

☐ Yes ☐ No

Screening and Procedures

☐ Oral Health Risk Assessment

☐ Subjective Hearing-Parental observation/concerns

☐ Subjective Vision- Parental observation/concerns

Developmental Surveillance

☐ Social-Emotional ☐ Communicative

☐ Physical Development ☐ Cognitive

Psychosocial/Behavioral Assessment

☐ Yes ☐ No

Screening for Abuse

☐ Yes ☐ No

Screening If At Risk

☐ IPPD _____ (results)

☐ Lead level _____ mcg/dl

Immunizations:

☐ Immunizations Reviewed

☐ Immunizations Given & Charted – if not given, document rationale

☐ DTaP ☐ IPV

☐ HepB ☐ Hib

☐ PCV ☐ Rota

☐ Influenza

☐ MCIR Checked/updated

☐ Acetaminophen _____ mg. q.4 hours

Patient Unclothed ☐ Yes ☐ No

Review of Systems N	Review of Systems A	Physical Exam N	Physical Exam A	Systems
☐	☐	☐	☐	General Appearance
☐	☐	☐	☐	Skin/nodes
☐	☐	☐	☐	Head/Fontanel
☐	☐	☐	☐	Eyes
☐	☐	☐	☐	Ears
☐	☐	☐	☐	Nose
☐	☐	☐	☐	Oropharynx
☐	☐	☐	☐	Gums/palate
☐	☐	☐	☐	Neck
☐	☐	☐	☐	Lungs
☐	☐	☐	☐	Heart/pulses
☐	☐	☐	☐	Abdomen
☐	☐	☐	☐	Genitalia
☐	☐	☐	☐	Spine
☐	☐	☐	☐	Extremities/hips
☐	☐	☐	☐	Neurological

☐ Abnormal Findings and Comments

If yes, see additional note area on next page

Results of visit discussed with parent

☐ Yes ☐ No

Plan

☐ History/Problem List/Meds Updated

☐ Referrals

☐ WIC ☐ Early On®

☐ Transportation

☐ Maternal Infant Health Program (MIHP)

☐ Children Special Health Care Needs

☐ Other referral _____

☐ Other _____

Anticipatory Guidance/Health Education

(check if discussed)

Safety

☐ Appropriate car seat placed in back seat

☐ Keep home and car smoke-free

☐ Avoid burns (stove, etc.): lower water heater temperature

☐ Don't leave baby alone in tub/ high places

☐ Childproof home (hot liquids, alcohol, poisons, medicines, outlets, cords, small-sharp objects, plastic bags, safety locks)

☐ Keep in highchair/playpen when in kitchen

☐ Limit time in sun/use sunscreen on baby

☐ Don't use baby walkers

Nutrition

☐ Breastfeed or give iron-fortified formula

☐ Cup of water/juice – limit juice

☐ Avoid foods that contribute to allergies

☐ Introduce solid foods at 4-6 months

☐ Wait one week or more to add new food

Oral health

☐ Don't put baby to bed with bottle

☐ Discuss teething

☐ Assess fluoride/clean baby's teeth daily

Infant Development

☐ Use upright seat so baby can see family

☐ Talk, sing, play music, and read to baby

☐ Daily and Bedtime Routine (put baby to bed awake)

☐ Safe Exploration Opportunities

☐ Put baby to sleep on back/Safe Sleep

Family Support and Relationships

☐ Family Planning

☐ Chose responsible babysitters

☐ Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

☐ Consider parenting classes/support groups/Playgroups

Other Anticipatory Guidance Discussed:

Next Well Check: 9 months of age

Developmental Surveillance on Page 2

Page 3 required for Foster Care Children

Medical Provider Signature:

PAGE 2 – WELL CHILD EXAM – INFANCY: 6 Months – Developmental Surveillance
(This page may be used if not utilizing a Validated Developmental Screener)

Date	Child's Name	DOB

Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes	No	
☐	☐	Please tell me any concerns about the way your baby is behaving or developing:
☐	☐	My baby seeks comfort when upset.
☐	☐	My baby smiles and laughs.
☐	☐	My baby says things like "da da" or "ba ba".
☐	☐	My baby eats some solid foods.
☐	☐	My baby sits with help/support.
☐	☐	My baby can pick up objects.
☐	☐	My baby likes to look at and be with me.
☐	☐	My baby rolls over.

Ask the parent to respond to the following statements:

Yes	No	
☐	☐	I am sad more often than I am happy.
☐	☐	I have people who help me when I get frustrated.
☐	☐	I am enjoying my baby more days than not.
☐	☐	I have a daily routine that seems to work
☐	☐	I keep in contact with family and friends.
☐	☐	I feel safe with my partner.

Provider to follow up as necessary.

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Infant Development	Yes	No	Parent Development	Yes	No
Turns to sounds/voices	☐	☐	Parent shows confidence with baby	☐	☐
Can be comforted most of the time	☐	☐	The parent comforts baby effectively	☐	☐
Smiles, squeals and laughs responsively	☐	☐	Parent and baby are interested in and respond to each other	☐	☐
Has no head lag when pulled to sit	☐	☐	Parent seems depressed, angry, tired, overwhelmed, or uncomfortable	☐	☐
			Parent notices and responds to baby's wants and needs	☐	☐

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. *(Bright Futures: Guidelines for health supervision of Infants, Children, and Adolescents)*

Additional Notes from pages 1 and 2

Medical Staff Signature	Medical Provider Signature

THIS PAGE IS REQUIRED FOR FOSTER CARE CHILDREN
PAGE 3 – WELL CHILD EXAM – INFANCY: 6 Months

Date	Child's Name	DOB

Name of person who accompanied child to appointment	☐ Parent ☐ Foster Parent
Phone number of person who accompanied child to appointment	☐ Relative Caregiver (specify relationship) ☐ Caseworker

Physical completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements

☐ Yes Please attach completed physical form utilized at this visit
☐ No If no, please state reason physical exam was not completed

Developmental, Social/Emotional and Behavioral Health Screenings (must use validated tool)

Always ask parents or guardian if they have concerns about development or behavior. (You must use a standardized developmental instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening completed: Date _____

Screener Used: ☐ ASQ ☐ ASQSE ☐ PEDS ☐ PEDSDM
☐ Other tool: Score: _____

Referral Needed: ☐ No ☐ Yes

Referral Made: ☐ No ☐ Yes Date of Referral: _____ Agency: _____

Current or Past Mental Health Services Received: ☐ No ☐ Yes (if yes please provide name of provider)

Name of Mental Health Provider: _____

EPSDT Abnormal results:

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.):

Medical Staff Signature	Date	Medical Provider Name (Please print)

Address	Telephone Number

This form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Department of Human Services, Michigan Association of Health Plans, and Michigan Association of Local Public Health.

FOSTER PARENT/CAREGIVER HANDOUT SHEET

Your Child's Health at 6 Months

Milestones

Ways your child is developing between 6 and 9 months of age.

- Plays games like "peek-a-boo"
- Babbles, imitates vocalizations
- Responds to own name
- Feeds herself with fingers and starts to drink from cup
- Enjoys a daily routine
- Sits up well and may pull to stand
- Crawls, creeps, moves forward by scooting on bottom
- May be unsure of strangers
- May comfort self by sucking thumb or holding special toy
- May get upset when separated from familiar person

For Help or More Information:

Breast feeding, food and health information:

- Women, Infant, and Children (WIC) Program, call 1-800-26-BIRTH
- The National Women's Health Information Center Breastfeeding Helpline. Call 1-800-994-9662, or visit the website at: www.4woman.gov/breastfeeding
- LA LECHE League – 1-800-LALECHE (525-3243). Visit the website at www.lalecheleague.org
- Text4Baby for health and development information – http://www.text4baby.org

Car seat safety:

- Contact the Auto Safety Hotline at 1-888-327-4236. Visit the website at www.safercar.gov
- To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at www.seatcheck.org

Toy and Baby Product Safety:

Consumers Product Safety Commission, 1-800-638-2772 or www.cpsc.gov

Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or www.usa.safekids.org

If you're concerned about your child's development:

Contact Early On Michigan at 1-800-327-5966 or Project Find at http://www.projectfindmichigan.org/ or call 1-800-252-0052.

For information about childhood immunizations:

Call the National Immunization Program Hotlines at 1 (800) 232-4636 or online at http:/www.cdc.gov/vaccines.

Domestic Violence hotline:

National Domestic Violence Hotline – (800) 799-SAFE (7233) or online at http://www.ndvh.org

Safety Tips:

Make your home safe before for your baby starts to crawl. You will need to keep doing this for several years.

- Put away small objects and things that break
- Tap electric cords to the wall; put covers on outlets
- Put safety gates at the top and bottom of stairs
- Store poisons and pills in a locked cabinet
- Poison Control Center: 1-800-222-1222

Baby walkers cause more injury than any other baby product. Instead of a walker, use a seat without wheels or put your baby on his tummy on the floor.

Health Tips:

Signs your baby is ready to start solid food:

- She can sit up with little or no support
- She shows you she wants to try your food
- She can use her tongue to push food into her throat

Your baby will let you know when he has had enough to eat. Stop feeding your baby when he spits food out, closes his mouth, or turns his head away.

Let your baby begin to learn to drink from a cup. Put water, breast milk, or formula in it. Don't let your baby take a bottle to bed.

Continue to put your baby to sleep on her back. Keep soft bedding and stuffed toys out of the crib. Make sure your baby sleeps by herself in a crib or portable crib.

Parenting Tips:

Show your baby picture books and talk about the pictures. Sing simple songs and say nursery rhymes over and over.

Give your baby plenty of time to play on his tummy on the floor. Put toys just out of reach so he will try to crawl. Start play simple games together like "Peek-a-Boo", "Pat-a-Cake" and "So Big".

Make regular times for eating, sleeping and playing with your baby.

When you are a parent, you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1-800-942-4357 (in Michigan). They will not ask your name and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

From the Institute for Health Care Studies at Michigan State University.