PART C AND THE ROLE OF THE NURSE

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PART C AND THE ROLE OF THE NURSE

The role of the public health nurse in the early identification of children with physical disabilities and/or developmental delays has been and will always be a vital component in assuring the early intervention and appropriate referral for further assessment and/or treatment. This is especially true for all health professional providers who are in the unique position to observe children and their families through health assessments conducted on babies and young children at regular and frequent intervals.

A national survey conducted by Brewer and Kakalik (1979) concluded that a major problem was not the lack of available services, but rather, the accessibility of these services. This study further concluded that the current service delivery system for handicapped children was so "complex and disorganized" that it defied efficient and effective operation. This process has been ongoing for the past 14 years.

In October of 1986, Congress passed an exciting new bill with the intent of coordinating, perhaps for the first time for many birth through 2 year old children and their families with disabilities, a comprehensive, multidisciplinary, interagency service system. This new bill, PL 99-457, contains amendments to the Education of the Handicapped Act (EHA) critical in the expansion of services to include an early intervention program for handicapped infants and toddlers 0 through 2 years of age and their families. This is now known as Part C, of the Individuals with Disabilities Education
Act -- IDEA.

Part C challenges all professionals to work collaboratively in order to develop the best plan of care to "enhance the development of handicapped infants and toddlers; to minimize their potential for developmental delay" and to "enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps." An important component of Part C is to encourage family empowerment, service coordination and interagency cooperation. It was up to each state to develop and implement policies and plans to comply with Part C regulations. Each state has been and is unique in its approach and implementation.

One section of Part C mandates the establishment of a State Interagency Coordinating Council (CICC) composed of parents, public and private providers, a state legislator, higher education and agency representatives, all appointed by the Governor.

The Colorado Department of Education is the lead agency for the implementation of Part C in Colorado. The CICC (Colorado Interagency Coordinating Council) was developed to design Part C policy framework and to ensure that the parameters of Part C were developed and integrated to provide consistent and on-going services to those infants and toddlers and their families, thus satisfying Part C criteria for delivery of services.

In addition to the CICC, sixteen communities have been given community development grants to support local Interagency Coordinating Councils (ICC). The local ICCs are charged with coordinating a listing of local professional and para-professional specialty and natural community

resources. These resources may be called upon to participate as a multidisciplinary team in the assessment and evaluation of identified infants and toddlers and whose expertise is necessary to empower families to direct the provision of care for their child.

Each ICC is also charged with developing a system that ensures that the process of early identification is in place and that the process for referral for a multi-disciplinary evaluation is effective and occurs at no cost to the family. Each ICC also ensures that children in need of further services and supports will have access to those services and supports.

Because Colorado promotes the use of its natural supports and services, infants and toddlers have increased accessibility to more available programs. Colorado maintains that these supports and services are to be delivered in a culturally sensitive manner.

The Colorado Department of Education and the Colorado Department of Health are challenged to work collaboratively with the development of the Rural County Project. In very sparsely populated counties in which there are few children with special needs, the Rural County Team serves as a resource to provide local communities with current Part C information and technical assistance to work collaboratively to ensure the accessibility of services to identified infants/toddlers and their families.

FREQUENTLY ASKED QUESTIONS:

The Public Health Nurse has been identified as one of fourteen qualified disciplines to be actively involved in the provision of early intervention services as part of a comprehensive statewide plan.

The Public Health Nurse is unique in that he/she has the skills to assess the overall health status of the child and the family.

Why is the PHN such an integral person in the Part C process? What is his/her function and how does s(he) access the system to advocate for the child? It is hopeful that the following section will answer your more frequently asked questions regarding the PHN role and Part C.]

IS THE PART C EARLY IDENTIFICATION AND REFERRAL PROCESS NEW FOR PUBLIC HEALTH NURSES?

No. Public Health Nurses should have in place a mechanism for early identification and service referral as well as a tracking system to ensure that families are able to access needed care and that such care is consistent, on-going and periodically reviewed for effectiveness and change. **What appears to be new is the requirement mandating providers, including public health nurses, to collaborate with other professionals and the family to avoid duplication of services.**

WHAT IS COLORADO'S PART C'S ELIGIBILITY CRITERIA?

Those children 0 through two years of age with:

1. Significant developmental delays in at least one or more of the following areas of development: cognition, communication, physical including vision and hearing, social or emotional and adaptive.

2. Children with conditions associated with significant developmental delays, but who may not be exhibiting developmental delays at the time of diagnosis. Those identifiable conditions include, but are not limited to:

   * Chromosomal syndromes and conditions associated with mental retardation.
   * Congenital syndromes and conditions associated with delays in development.
   * Sensory impairments.
   * Metabolic disorders.
   * Prenatal and perinatal infections and significant medical problems.
   * Low birth weight infants weighing less than 1,000 grams.
   * Postnatal acquired problems known to result in significant developmental delays.

3. Children whose parent(s) experience developmental disabilities as determined eligible by the Division of Developmental Disabilities.

DOES EVERY COUNTY HAVE AN ICC?

At present there are 16 organized ICCS located in the larger populated areas. It is the responsibility of the Rural County Project at the Colorado Department of Health to assist those rural communities that have less than 1% of the birth population to organize existing services and supports. It is important that the Public Health Nurse be a member of the local ICC. Often, it is the Public Health Nurse who begins the process with the identification of a child seen at the Well Child, HCP Clinic or with other case finding efforts.

HOW DOES CHILD FIND FIT INTO PART C?

The function of Child Find is to create awareness among the general public of typical and atypical child development and to involve the participation of local community personnel, public health professionals, volunteers, community members, early childhood personnel, parents, caregivers. It is an informational and management system organized to link infants and toddlers and their families with community resources and medical care.

The purpose of Child Find is to identify those infants and toddlers eligible to receive services as mandated by P.L. 99-457. Child Find may be known by other names such as Family Connects and Resource Access for Families with Infants and Toddlers. Child Find is part of the larger child identification system, e.g., community screenings, setting up referral networks.

WHERE IS CHILD FIND FOUND?

Child Find is found through local school districts and BOCES.
The Colorado Department of Education (303-866-6710) has developed and published a CHILD FIND DIRECTORY listing Child Find offices and contact persons throughout the State.

HOW DO YOU ACCESS BOCES?

BOCES (Board of Cooperative Educational Services) links local school districts together to provide special education services to smaller school districts on a regional basis. Each BOCES office is listed in the Child Find Directory.

WHAT IS THE STANDARD SCREENING TOOL?

Although there is no one screening tool for development used, the one tool commonly used by PHNs is the Denver II. The Denver II is only a screening tool for developmental assessment. Both the health history and physical examination are vital parts of the screening process. Parents can provide a more accurate picture of their child's current behavioral patterns and characteristics, e.g., sleeping behaviors, friendships, speech, non-verbal cues and can validate the overall assessment process and outcome.

WHAT ARE SOME COMMONLY USED ASSESSMENT TOOLS?

Bailey, Batelle, Minnesota Child Development Inventory and available developmental checklists. Parental information is most helpful in determining whether or not a child's development is delayed. Parent report has been used to supplement information obtained by direct screening and as the primary means by which information about the child's skills is obtained. Recent research also indicates that parent concerns often parallel professional concerns.

WHAT IS AN IFSP? The IFSP (Individualized Family Service Plan) is developed by the multidisciplinary team which includes the family and is required by Part C. The IFSP is to be reevaluated at least once a year, but may be reevaluated as the need arises and must contain statements of:

1. The infant's or toddler's present levels of physical development, cognitive development, language and speech development, psychosocial development and self-help skills.

2. The family's strengths and priorities relating to enhancing the development of the child with special needs.

3. The major outcomes expected to be achieved for the child and the family and a timeline for achieving these outcomes. This is to include any needed services and/or modifications.

4. Identified services needed to meet the special needs of the child and the family, including the frequency, intensity and the method of service delivery.

5. Start of care and anticipated length of care.

6. Name of service coordinator, designated by the family, who will be responsible for the implementation of the plan of care and the coordination of all involved agencies and personnel. The service coordinator will be responsible for the transition to the child's local school system as the child approaches his/her third birthday. This person may or may not be the Public Health Nurse.

The IFSP is a sharing of information with professionals and paraprofessionals by the family, an empowering tool for families and a document to formalize a plan of care and action.

IS THERE A STANDARDIZED IFSP FORM?

There is no standardized IFSP form used in Colorado, but enclosed in your packet of materials is a sample IFSP that may serve as a guide to you.

WHO CAN INITIATE THE IFSP?
Anyone involved with the family can initiate an IFSP including parents. Communities should plan together to ensure that IFSP's are initiated for families in a timely manner.

HOW ARE Part C SERVICES FUNDED:

There are existing sources of funding for services, ie., through the CCB's, Medicaid and HCP. However, the federal government has provided Part C funding for the enhancement and coordination of programs for young

children and their families. A required component of these programs has been parental involvement.

ARE THE PARENTS RESPONSIBLE FOR PAYMENT OF THE INITIAL ASSESSMENT?

No. The law provides that every identified child receive his/her initial assessment evaluation(s) free of charge.

WHO AUTHORIZED REIMBURSEMENT FOR SERVICES:

While evaluation is free (mandated), the services are not. After evaluation recommendations for agreed upon care between the multidisciplinary team and the family, the case manager/service coordinator explores resources available, e.g., medicaid, SSI, HCP. If none apply, it is up to the community ICC to help meet the needs of the family.

WHY IS THE PUBLIC HEALTH NURSE SO IMPORTANT?

The PHN is an important source of early identification throught Well Child/Well Baby expertise. PHNs have the health background necessary for the recognition of existing or potential problems. The PHN having a good sense of community resources and knowing the family, can be an integral person in the development of an IFSP.

WHAT IS PART B:

Part B of P.L. 99-457 requires that states serve 3-5 year old children with special needs. Part C provides for the transition from early intervention to preschool services.

WHAT IS THE FUNCTION OF THE COLORADO REGISTRY FOR CHILDREN WITH SPECIAL NEEDS?

The Colorado Registry was established by the Colorado Department of Health for the purpose of tracking infants identified at birth as being at high risk. The Registry includes babies and young children who have special needs because of birth defects and developmental disabilities or who are at risk for delays in their development.

One important mission of The Registry is, with parental consent, to link children with services in their home community including the Public Health Nurse. The Registry is completely confidential.

The Registry receives information from birth certificates, hospitals, laboratories, the Health Care Program for Children with Special Needs and health care providers.

SUMMARY OF PHN ACTIVITY AS RELATED TO Part C

Part C PROCESS	**ACTIVITY**	**LOCAL OPTION What happens in your community?**
The PHN: **Screens** and **assesses** the physiological,psychologicaland developmental characteristics of the infant/toddler and the priorities of the family when they result in early identification, referral and intervention. Early identification may be accomplished through:	Well Child Clinics health history newborn and child assessments developmental screenings Newborn and other Home Visits Case Finding School Screening Child Care EPSDT Outreach Direct Referral Community Center Board (CCB) Screening for Child Find Head Start Parental Concern	
When a child is suspected of having developmental delay, **referrals** may be made to:	Child Find (Early Identification System) Local ICC BOCES CCBs	

The PHN **Case Management/Service Coordination** may include: 1. Documentation of the most recent physical exam and/or provide a health history. 2. Acting as the liaison between family, physician and other members of the multi-disciplinary team. 3. Secure PCP (Primary Care Provider), if one is not in the area. 4. Working with EPSDT for Medicaid children. 5. Helping families access reimbursement source, ie., Medicaid. 6. Monitoring child's progress in all areas: psychosocial, emotional, clinical. 7. Ensuring that: - family understands all aspects of their child's condition and needed care - the importance of keeping all appointments 8. Helping to overcome barriers and referring as appropriate. 9. Being selected by family as service coordinator or assisting family in selecting a service coordinator. 10. Following up as indicated.	Well Child Services	

As a **member of the ICC or multi-disciplinary team**, the nurse may participate in:	Integration of nursing assessment and interventions within the IFSP. Implementation of other components of the IFSP in collaboration with team members and family. Developing IFSP with team and family. Ensuring that the family: 1. Has the right to self-determination. 2. Is the final decision-maker, except in cases of abuse and/or neglect.	
For those counties without their own ICC: **Access Rural County Project Response Team**	Call Colorado Department of Education to reach a Rural Response Team member:	

References:
Brewer, G.D., & Kakalik, J.S. (1979) Handicapped Children, Strategies for Improving Services. New York: McGraw-Hill Book Co.

A Brief Introduction to P.L. 99-457 A New National Agenda for Young Special Needs Children. Early Childhood Update, Spring 1987. Pascal Trohanis, START, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill

Part C DEFINITIONS

COLORADO'S Part C'S ELIGIBILITY CRITERIA?

Those children 0-3 years of age with:

1. Significant developmental delays in at least one or more of the following areas of development; cognition, communication, physical including vision and hearing, social or emotional and adaptive.

2. Children with conditions associated with significant developmental delays, but who may be not be exhibiting developmental delays at the time of diagnosis. Those identifiable conditions include, but are not limited to:

   * Chromosomal syndromes and conditions associated with mental retardation.
   * Congenital syndromes and conditions associated with delays in development.
   * Sensory impairments.
     Metabolic disorders.
   * Prenatal and perinatal infections and significant medical problems.
   * Low birth weight infants weighing less than 1,000 grams.
   * Postnatal acquired problems known to result in significant developmental delays.

3. Children whose parent(s) experience developmental disabilities as determined eligible by the Division of Developmental Disabilities.

CHILDREN AT RISK: Children with biological, psychological or environmental factors that have a definite or potentially negative effect on normal development.

DEVELOPMENTAL DELAY: A delay in one or more of the following areas: cognitive development; physical development; vision and/or hearing; language and speech development; self-help skills.

EARLY INTERVENTION SERVICES: Services/interventions designed to meet the growth and developmental needs of each Part C eligible child developed collaboratively with parents and professional personnel. The need for early intervention is based on the premise that the child's maximum potential can only be realized through such early intervention.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP): A written care plan developed as a collaborative effort between the family and members of the interdisciplinary team specifying how identified assessed needs of the child will be met. The family has the right to self-determination and is the final decision-maker except in the cases of abuse or neglect.

NURSING STANDARDS OF CARE IN COLLABORATION WITH FAMILY AND TEAM MEMBERS (as applied to Part C Activities and as related to standards of nursing process).

ASSESSMENT	-	comprehensive, accurate and relative data collection.
DIAGNOSIS	-	data analysis based on scientific principles and professional judgements.
OUTCOME IDENTIFICATION	-	identification of expected outcomes supported by the health and development of the child and the values and priorities of the family.
PLANNING	-	steps taken in participation of the IFSP to assure outcome assessment, etc.
IMPLEMENTATION	-	to begin those actions identified on the IFSP that maintain, promote or restore health and development.
EVALUATION	-	systematic and ongoing data evaluation necessary for revision of diagnosis, outcomes and plan of care.

NURSING INTERVENTION: Any nursing action instituted to either prevent a potential health problem or treat an identified health problem in order to resolve that health problem.

NURSING ASSESSMENT: A process of data collection that identifies the child's strengths, weaknesses and needs within each of the eleven health patterns including as it applies to Part C:

- health perception/health management practices
- nutritional needs
- factors affecting activity, exercise and self-help as in neuromuscular, cardiovascular, respiratory and developmental functioning
- elimination patterns
- cognitive/perceptual abilities
- psychosocial/social supports

Nursing Assessment con't.

- self-perception/self-concept

- problems/concerns with sexuality/reproductive functioning

- family values, beliefs, concerns and priorities within their cultural context

- family resources and needs, especially as they relate to ability to provide a safe, nurturing environment that can optimally stimulate the child's development

NURSING CARE PLAN: A series of identified nursing diagnoses and interventions specifically designed to achieve the desired physical, psychosocial and developmentally related outcomes for child and family.

CASE MANAGEMENT/SERVICE COORDINATION

Case management/service coordination is and has been an integral part of nursing in the care of children and their families. It is a process that promotes the identification, assessment, organization, coordination and utilization of resources, care and services to meet the needs of the child and his/her family.

1. Service coordinators interact within a service network to ensure access to affordable and appropriate services in a timely manner. Care and services should be continuous, coordinated and comprehensive.

2. The philosophy of service coordination implies an active partnership WITH the family in the form of a collaborative relationship that facilitates securing of services.

3. The strength, needs and goals of the family drive the system. Family input and involvement are essential if recommended actions are to be successfully completed.

4. Service coordination involves assisting families to manage their own situations by providing the level of support appropriate to the assessed needs of the child and family. Inherent in this process is the ability to empower families to manage these situations in the future.

The final decision of choice of service coordinator rests with the family. The service coordinator could either be a professional and/or paraprofessional who will assist in the implementation of the outreach and case finding activities and is a shared responsibility of the family and the multidisciplined team members.

ROLE OF THE CASE MANAGER

1. Outreach - facilitating early entry into care system and encouraging on-going and systematic care; developing a strong referral network, identifying and reducing barriers to continuity of care.

2. Assessment - determining, in a comprehensive manner, the family's, medical, nutritional, psychosocial, educational and financial needs. The strengths of the family should be identified and emphasized. The assessment process forms the foundation for planning the direction of care.

3. Care Planning - developing the Individualized Family Service Plan (IFSP) focusing on services and resources required to address the particular needs of the family. This includes the goals, methods and activities involved in service delivery, monitoring and evaluation, including inter-disciplinary involvement. The case manager must be committed to assisting and allowing the client to define pertinent issues and needs and to select preferred action plans. The case manager and the family should prioritized goals and specify a time table for completion. The IFSP is a family empowerment contract that includes all the structured plans and resources necessary for continuous and on-going care.

4. Service Planning, Coordination and Referral - establishing access for service delivery by assisting the family in arranging for and accessing appropriate care and services in a timely fashion.

5. Follow-up/Monitoring - assuring that services are accessed and delivered, assessing barriers to service delivery and documenting reasons why services are not accessed. The case manager should also assess on-going progress and make modifications with the family in the IFSP as necessary.

6. Advocacy - a supportive relationship with the family in promotion of the IFSP. The best interests of the family takes precedence and are considered primary in any selected action. The skills of the family should be developed to enable them to problem solve as well as to access and utilize services.

INDIVIDUALIZED FAMILY SERVICE PLAN

Child's Name ____________ Date ____________ Date for Evaluation ____________

CONCERN/PRIORITY	PLAN OF CARE	INDIVIDUAL RESPONSIBLE FOR FOLLOWUP
1. Health Finding a doctor/dentist or other health care provider Immunizations Vision/hearing services Family Planning Other		
2. Psychosocial Counseling/Mental Health		
3. Equipment <u>medical:</u> wheelchair crutches braces feeding pumps oxygen other <u>Education based:</u> communication board other		

4. Social Services EPSDT/Medicaid AFDC Finances Food Stamps SSI Medical Insurance		
5. Transportation		
6. Housing Paying for electricity, heat, phone		
7. Food/Nutrition Paying for food/formula		
8. Respite Care Child Family		
9. Transition to Part B		
10. Transition from High School		
Other		

HEALTH HISTORY

Interviewer ______________________________
Date _______________________________________

DEMOGRAPHIC DATA

Child's Name _________________________ Birth Date ________________
Address _____________________________ Telephone ________________
County ______________________________ School ____________________
PreSchool ________________
Early Developmental Center
____
Parent/Guardian's Name ____
Telephone: Home: __________________ Work: _________________
Language Spoken at Home _________________

Primary Care Physician ____
Address and Phone ____

FAMILY DATA
Please list family members living within your household:

Name	Sex	Age	Address (if diff.)	Relation-ship	Occupation

INTERVIEW DATA
1. Brief description of your concerns about your child: __________
____
____
____
2. What kind of help would you like for your child? ______________
____3.
Is this child:
___adopted ___a foster child ___a step child ___your own

PRENATAL HISTORY (ABOUT YOUR PREGNANCY)
1. Number of pregnancies: ______ Number of live births: ______
2. How would you describe your general, overall health during pregnancy: ____
3. Did you have medical supervision during pregnancy? __yes __no

Were x-rays taken or tests done: ___yes ___no If yes, please give name and address of provider: ______________________

4. Do you remember taking any drugs/medications within 3 months before pregnancy: ___yes ___no If yes, which one: _________
____

5. Did you take any of the following during your pregnancy?

	FREQ.	DOSE	MONTH	?
Nicotine				
Alcohol				
Caffeine				
Antibiotics (which one)				
Street Drugs				
Sedatives				
Narcotics				
Diet Pills				
Other				

6. Did you have any of the following during your pregnancy?

	MONTH	DETAILS	?
Rubella (German Measles)			
Herpes			
Varicella (Chicken Pox)			
Syphilis/Gonorrhea			
T.B.			
Chlamydia			
Cytomegalovirus (CMV)			
Vaginitis			
Bleeding - first trimester			
Bleeding - second trimester			
Bleeding - third trimester			
Wgt. gain 30 or more pds			
Wgt. gain 15 or fewer pds			
Vomiting			
Edema (Swelling)			
Diabetes			
Injury/Accident			
Rashes: (dx.)			
Other			

PERINATAL HISTORY (ABOUT THE BIRTH)

1. How many weeks long was your pregnancy: ________________________2. How long was your labor: _________
3. Type of Delivery: ___ Vaginal ___ C-Section
4. Were you given any medicine for pain or to start contractions: ___yes ___no. If yes, please give details: __________________
____

5. Did you have any trouble with the birth: ___yes ___no. If yes, please describe: ____

6. Was the baby: ___Multiple birth ___Premature
   ___Post mature
7. Birth weight: ___lbs/kg Apgars: ___ 1 minute
   height: ___in./cm (if known) ___ 5 minutes

8. Were there any difficulties after delivery?
   ___Resuscitation ___Surgery ___Need Blood
   ___Infection ___Birth defects ___Jaundice
   ___Illness ___Seizures ___Injury
   ___Gagging/Vomiting ___Problem sucking ___Diarrhea
   ___Blood Problem ___Difficulty Breathing ___Need Oxygen
   ___Need Medication ___Other
   Details (Description, treatment, hospitalization): ____________
   ____
9. Did you and your baby go home at the same time: ___yes ___no.
   If no, why not? ____
10. PKU ___normal ___abnormal
11. Other genetic screening results, if known: ___________________
12. Cocaine test (urine) ___pos. ___neg.

NEONATAL PROBLEMS (ABOUT THE BABY'S FIRST MONTH)

1. Was you baby breast fed, bottle fed or both? __________________
2. Were there any feeding difficulties? __________________________
3. Did the baby have any of the following problems?
   ___Illness ___Gagging/Vomiting ___Jitteriness
   ___Fever ___Colic ___Allergy
   ___Diarrhea ___Constipation ___Infection
   ___Injury/Accident ___Skin problem ___Blue spells
   ___Seizures ___Difficulty sucking ___Lethargy
   ___Floppiness ___Fretful ___Seem stiff
4. Was there any change in temperament or activity level during the first year: ___yes ___no. If yes, please describe: ___
   ____

EARLY DEVELOPMENTAL RECORD

MILESTONES (when did you baby do the following?)

	0-3 mo	4-8 mo	9-12 mo	13-18 mo	19-24 mo	2-3 yr	?
Smiled responsively							
Cooing, vocalizing-not crying							
Holds head erect when upright							
Rolls over							
Grasp rattle							
Feeds self cracker							
Sits without help							
Transfer toy hand to hand							
Imitate speech sounds							
Pulls self to stand							
Shy with strangers							

Neat pincer grasp ___
Walked alone (10-15 steps) ___
Drinks from cup-some spilling ___
Uses spoon-spilling little ___
Speaks 3 words other than mama ___
Combines 2 different words ___
Attempt dressing ___

	0-3 mo	4-8 mo	9-12 mo	13-18 mo	19-24 mo	2-3 yr	?
Able to separate from mother							
Fully bowel trained							
Fully bladder trained							

1. Do you think your child's development has been similar to his/her siblings and to others of similar ages? ___yes ___no. If no, what do you think accounts for this difference? ___
___2.
Did your child have any illness or accident which may have affected his/her development? ___yes ___no. If yes, please describe: ___

HEALTH HISTORY

Communicable Disease Record: (Check all that apply)

___Chicken Pox ___Polio ___Scarlet Fever
___Rubella ___Impetigo ___Hepatitis
___Measles ___TB ___Strep/Staph Infection
___Whooping Cough ___Influenza ___Mononucleosis
___Mumps ___Herpes ___Venereal Disease
___Other

Vaccine:	(MONTH/DAY/YEAR)			DISEASE
DTP	1. ___	2. ___	3. ___	
Polio	1. ___	2. ___	3. ___	
Hib	1. ___	2. ___	3. ___	
Hep. B	1. ___	2. ___	3. ___	
MMR	___			
PPD	___			

Immunization Reaction ___
Lead Level ___pos. ___neg.
Medical Contraindications: ___

RECORD OF HEALTH PROBLEMS

	0-3 mo	4-6 mo	7-12 mo	19-24 mo	2-3 yr	?
Eye Problem ie. cataract						
Ear Infections						
Rashes/Skin problems						

Meningitis ___
Seizures ___
High Fever -- over 103 ___
Pneumonia ___
Food/Drug Allergies ___
Asthma ___
Anemia ___
Lead poisoning ___
Diabetes ___

	0-3 mo	4-6 mo	7-12 mo	19-24 mo	2-3 yr	?
Fractures						
Hospitalization						
Loss of consciousness						
Cardiac						
Kidney/Urinary						
Thyroid						
Musculoskeletal						
Orthopedic						
Eating						
Falling asleep						
Twitches/tremors						
Self-destructive behavior						
Temper tantrums						
FTT (Failure to thrive						
Other						

Does your child take any medication every day? ____ yes ____ no
If yes, please list: ___
If your child has a food or drug allergy, please describe what happens when that food or drug is taken: ___
___

REVIEW OF SYSTEMS

1. Does mother see child as well? ___
2. Recent weight gain or loss? ___

3. Head, Eyes Ears, Nose, throat, Mouth:
   a. Headaches

   b. Visual problems (difficulty seeing objects), strabismus

   c. Ear Infections: 3 or more in one year?
      Middle ear tubes
      Difficulty hearing TV

4. Respiratory: chronic cough, frequent colds, wheezing, pneumonia

5. Cardiovascular: cyanosis
shortness of breath
heart murmur

6. Gastrointestinal: eating problems, vomiting/diarrhea, abdominal cramping/pain, constipation

7. Urinary: urinary track infections, discharge, bedwetting, problem keeping dry during day

8. Skin: chronic rashes, easy bruising, eczema

9. Musculoskeletal: muscle pains (when, how often), problems with walking, running, skipping, hopping

10. Neurological: seizures, meningitis

DATE OF LAST PHYSICAL EXAM ______________________________________

FAMILY MEDICAL HISTORY

(Any family member/relative)

DISEASES	RELATIONSHIP TO CHILD	DETAILS
Migraine		
Allergies		
Blood Disease		
Birth Defects		
Cancer		
Diabetes		
Seizure disorder		
Hypertension		
MI/CVA		
Musculoskeletal		
Kidney		
Thyroid		
Emotional Illness		
Mental Health Therapy		
Tuberculosis		
Hearing Disorder		
Sickle Cell Disease		
Other		

FAMILY BACKGROUND DATA

(Any family member/relative)

PROBLEM	RELATIONSHIP TO CHILD	DETAILS

Hyperactivity as a child ____________________
Trouble learning to read ____________________
Trouble with arithmetic ____________________
Trouble with writing ____________________
Speech/Language problems ____________________
Behavior problems in childhood ____________________
Behavior problems in school ____________________
In trouble as an adolescent ____________________
Kept back in school ____________________
Other ____________________

SOCIAL DATA

1. Have there been significant family losses or changes in your home in the last year? ___yes ___no. Please explain: ______
____
____
____

2. What is your child's relationship like with the parent who is not present (at interview)? Please describe: ________________
____
____
____

3. In your family has there ever been a problem with:
____Alcohol ____Physical abuse ____Emotional problems
____Drug ____Sexual abuse ____Violence in Your Home
If yes, please explain: ______________________________
____
____
____
____

4. Please note any community agency presently serving your family:
____
____
____

5. What do you feel are your strengths as a family? ______________
____
____
____

6. What do you like most about being a parent? ____________________
____
____
____

7. Please list the three most positive things about your child:__
____
____
____
____

8. Do you understand the IFSP (Individual Family Service Plan) and the evaluation process? ___yes ___no
Please indicate in which area you need more information: ___
____
____
____
____

Are you having any difficulty with:

_____ Housing _____ Respite Care/Baby Sitting
_____ Food _____ Health Insurance
_____ Clothing _____ Health Care (including family planning)
_____ Other

If you have answered yes to any of the items listed above, please explain: ____
____
____
____
____
____

Please identify the person helping you and your family coordinate all the people, services and health care providers involved with your child and your family: ______________________________________ ______
____

If there is no one filling this role, please indicate the person whom you would like to help you coordinate people, services and health care providers helping your family: _______________________
____

HEALTH HISTORY EXPLANATIONS

The health history data can be collected in a prescheduled office meeting or a home visit. The parent/guardian may answer questions ahead of time and review/update the form with the public health nurse.

DEMOGRAPHIC DATA
This information is collected for baseline data and reference for the nurse.

FAMILY DATA
This data provides a compilation of baseline information for all family members and may be seen as most helpful as it may provide data suggesting family disruption, etc. which may impede the care of the child. The presence of an extended family who may be important to the child as they affect the child's health and access to medical care.

INTERVIEW DATA
The parent/guardian to describe their child's difficulties in their own words. The first two questions will help the nurse understand how the parent perceives his/her child's problem.

BIRTH HISTORY (4 PARTS)
This part includes prenatal, perinatal, neonatal, behavior/problems and infant behavior/problems. Information in this section may support a suggestion or confirmation of a child's medical problems, weight/height differences, learning or behavior difficulties, developmental delays and maternal-child attachment problems. It may identify risk factors and how they relate to the child's health.

Question 1 related to how many pregnancies and live births the mother had. The nurse can ascertain any difficulty becoming pregnant, delivering and if she suffered a fetal loss. Information may help the nurse understand what this pregnancy/child might mean to the mother.

Question 2 in the pre-natal section is valuable as it identifies when the mother first sought medical care. A young teen, ie., often delays seeking care, thus potentially placing her baby at increased risk. All of the drugs listed in question 3 have the potential to affect the fetus' growth and development. Narcotic use may have an adverse effect on development and may depress respirations in the neonate. Nicotine may impact infants with low birth weights and interfere with respiratory development. Fetal alcohol syndrome affecting the fetus' facial features, growth, neurologic status and behavior is characteristically seen in infants whose mothers drank undetermined amounts of alcohol
during their pregnancy.

Question 5 identifies certain infections that might adversely affect a fetus or neonate. Cytomegalovirus, a rare and severe congenital infections, may be associated with cerebral and ocular problems, organomegaly, jaundice, blood dyscrasias, pyschomotor retardation and deafness. Rubella may lead to problems such as growth retardation, eye defects, congenital heart disease, deafness, CNS defects, mental retardation, thrombocytopenic purpura and bone defects.

Herpes simplex or gonorrhea may be acquired through the birth process and may involve the liver, adrenal glands, CNS and respiratory system. Syphilis is usually passed transplacentally. T.B., varicella and rubella is associated with severe morbidity.

Question 5 includes possible high risk problems. Bleeding at any time during pregnancy is not expected and may relate to oxygen supply or placental problems as well as a warning of miscarriage. It has been documented that mothers who gain too much or too little weight may be malnourished or taxing their own systems with abnormal fluid retention, possibly compromising fetal growth and development.

Question 6 related to how many pregnancies and live births the mother had. The nurse can ascertain any difficulty becoming pregnant, delivering and if she suffered a fetal loss. Information may help the nurse understand what this pregnancy/child might mean to the mother.

The perinatal history questions the length of the pregnancy. Premature babies are more susceptible to: hyaline membrane disease, recurrent apnea, hypoglycemia, hyperbilirubinemia, anemia, hypothermia and neurological difficulties. Postmaturity may be related to an increased morbidity and mortality, especially after 45 weeks gestation.

Length of labor may indicate a precipitous delivery which may be linked with added risk for intracranial hemorrhage. Long labors may cause mechanical or hypoxic damage. Neurological problems may result from brief or prolonged labors. Medication or anesthesia may cause problems for mother and/or fetus. Hypoxia and shock may result from misuse of medication. Crying and breathing may be delayed. Anesthesia may have some influence on the initial bonding of mother and infant.

The Apgar score rates a newborn's heart rate, respiratory effort, muscle tone, color and response to tactile stimulation. A score of 8-10 indicates the infant is in the best possible general physical condition. A score of 5-7 is rated as fair and below 5 is poor. If the scores are known, they more support other collected data.

Question 7 in the perinatal section deals with the baby's health directly after birth through the first few days of life. Resuscitation may follow respiratory distress or signs of anoxia. Erythroblastosis fetalis, anemias, RH incompatibility, hemorrhage and polycythemia may necessitate transfusions of blood or blood products. Birth defects may be associated with various medical problems, physical anomalies, developmental delays and mental retardation. Seizures and jitteriness may be linked to neurological problems or anomalies, rubella, infection, hypoglycemia, fetal alcohol syndrome, drug withdrawal and hypocalcemia. Gagging and vomiting may suggest CNS involvement, esophageal atresia, or infection. Diarrhea may cause dehydration and fluid/electrolyte imbalance. An infant having difficulty sucking may have a cardiac or CNS-related problem.

The neonatal/behavior problems relate to the first month of life. Breast-feeding and bottle feeding may both have benefits for the baby. You might want to keep some of the following questions in mind. If the mother breast-fed, how long did she continue it and what was the experience like for her and for the baby. Did the baby have any colic or food intolerance. did the mother have any trouble with breast-feeding or bottle feeding. The feeding experience can offer key information about developing maternal-child attachment, a sensitive infant or an infant with possible health problems.

Question 3 relates to any problems the baby may have during the neonatal period. Illness in the infant can suggest diseases such as meningitis, sepsis, necrotizing, enterocolitis, UTI, viruses, etc. Seizures may be linked to fevers, neurological problems, anomalies and syndromes, late onset of hypoglycemia or hypocalcemia or sensitivities. Constipation may be lined with feeding, but can also be associate with Hirschsprung's disease (along with diarrhea episodes, failure to thrive, vomiting and abdominal distention.) Gagging/vomiting maya be suggestive of CNS or intestinal pathology. A

complete informational history on sustained trauma should be obtained and "clue in" to related data in other areas of the questionnaire. An infant is especially prone to falls, motor vehicle accidents, aspiration or ingestion of foreign objects, poisoning, burns and drowning. Parents may not have received safety prevention information, but abuse/neglect must always be considered as well. Skin problems may be related to infection, ie., staph, strep, or to sensitivities, ie., eczema. Blue spells and difficulty sucking may suggest cardiac difficulties or CNS problems. Jitteriness may indicate hypocalcemia or hypoglycemia.

Question 1 is an open-ended question and gives the interviewee the chance to offer thoughts, feelings, and impressions of the infant which may support previous data obtained in the perinatal/neonatal areas and may support data suggestion difficulties in: maternal-child attachment, activity/attention problems and atypical behavior.

DEVELOPMENTAL HISTORY

The early developmental record deals with the acquisition of age-appropriate gross motor, fine-motor, speech/language and personal/social skills. It is set up chronologically with early milestones listed first.

Milestones	Normal Range
Smiles responsively	0-3 months
Cooing, vocalizing-not crying	0-3 months
Holds head erect when upright	2-3 months
Rolls over	4 months
Grasp rattle	2-4 months
Feeds self cracker	4-6 months
Sits without support	6-8 months
Transfer toy from hand to hand	4-8 months
Imitates speech sounds	4-8 months
Pulls self to stand	9-10 months
Shy with strangers	5-10 months
Neat pincer grasp	11-13 months
Walks well alone (10-15 steps)	11-12 months
Drinks from cup - little spilling	13-18 months
Uses spoon - spilling little	19-24 months
Combines 2 different words	19-24 months
Attempts dressing	2-3 years
Able to separate easily from mother	2-3 years
Fully bowel trained	2-3 years
Fully bladder trained	2-3 years

Accident prevention and safety are important issues. Accidents are the sixth leading cause of death in children under 1 year of age. The leading causes of death in infants are: accidents, ingestion/inhalation of food/objects, mechanical suffocation, motor vehicle accidents, fires/burns and falls. Motor vehicle accidents are the leading cause of accidental deaths in children 1-4 years followed by: fire/burns, drowning, ingestion/inhalation or foreign objects and falls.

HEALTH HISTORY

Questions related to communicable diseases include typical childhood s\diseases which may have significance for the child's present/future health. Whooping cough, ie., might be seen in a child <6 years who has not received proper pertussis immunization. Strep/staph infection or impetigo are important because of complications of rheumatic heart disease and or glomerulonephritis. Polio and TB should be asked as their incidence is
increasing in recent years.

Certain illness or diseases may have occurred during critical developmental periods and thus have implications for the child's educational performance.

Eye Problem/Cataract:	Detrimental effect on vision - compromise development and learning.
Ear Infections:	Detrimental effect on hearing; speech and language problems.
Rashes/Skin Problems:	General health; allergies; communicable disease; parental reactions/coping.
Meningitis:	Hearing; learning problems, neurological impairment.
Seizures:	Medication side effects; emotional consequences; medical problems; neurological implications for development; family counseling needs related to illness and health management.
High Fever - over 103:	Neurological impairment; medical problems.
Pneumonia:	Exercise/exertional tolerance; repeated infections.
Food Allergy:	General health problems; specific complications.
Asthma > 2 year	Medications; home/environmental management; increased URI's for age group; emotional consequences of chronic illness; family financial/emotional stress; developmental concerns; family counseling related to illness and health management.
Anemia:	Weakness; medical problem/nutritional needs; thalassemia trait.
Lead Poisoning:	Encephalopathy; nutritional problems; neurological problems; learning problems; environmental concerns.

Diabetes:	Medical problems/complications; hospitalizations; emotional consequences; altered concentration in play/learning related to glucose level; family financial stress; good skin care; dietary/nutritional needs; family education and counseling needs related to illness and health management.
Fractures:	Medical problems and complications; nutritional needs; mobility problems; medications; immobility leading to constipation, muscle atrophy; rehabilitation; potential growth problems.
Hospitalization, Surgery, Injury, Accident:	Medical problem/complications; degree/type of disability; family financial stress.
Loss of consciousness:	Neurological complications/sequelae, behavioral changes.
Cardiac:	Exertional tolerance; sleep/rest needs; poor weight gain; anoxia; general health and infection susceptibility; medications; family financial and emotional stress; family education and counseling needs related to illness and health management.
Kidney/Urinary:	Medical problems/surgery and repeated hospitalization; developmental concerns, ie., hypospadias; medications; diet needs/restrictions; altered growth; family financial/emotional consequences; family educational/counseling needs related to illness and health management.
Thyroid:	Level of activity; visible hormonal effects; medication/surgery.
Musculoskeletal/Orthopedic	Degrees of deformity/disability; medication/complications; altered ambulation and limb manipulation; prosthetics; medications.
Frequent night waking:	Anxiety, insecurity, inconsistent night time routines; emotional insult/painful stimuli (breath holding); alteration in parent-child relationship.
Self-destructive behavior:	Attention needs; emotional disorder; neurological impairment; family dynamic roles/stresses.
Temper Tantrums:	Normal developmental occurrence (18 mo-3 yrs): discipline methods; attention needs; counseling needs as related to discipline/child development.
FTT (Failure to Thrive):	Medicines; systemic illness or chromosomal abnormality; endocrine problems; maternal-child deprivation/attachment problems; child abuse or neglect; feeding problems; low birth weight; chronic or recurrent infection.

CURRENT HEALTH HISTORY
The purpose of this section is to gather pertinent health data, test results and reports in one area of this form.

Review of Systems is important because it has implications not only for the child's present health status, but for the child's educational experience.

Head/Face:	Masses; neuroproblems; repeated injury; abnormal bone development; hydrocephaly.
Skin:	Endocrine problems; infections; rashes; systemic illness; allergies.
Hair/Nails:	Endocrine problems; fungal infection; cardiac problem (clubbing).
Eyes:	Infections; vision problems; allergy; structural abnormalities.
Ear/Nose/Throat:	Hearing/speech problems; infections; allergy; nasopharynx structural defects.
Teeth:	Teeth eruption; first visit; dental caries.
Breasts:	Endocrine or dietary problems; gynecomastia; structural abnormalities.
Cardiac:	Congenital or acquired.
Respiratory:	Infections; allergy; chronic infections.
Gastrointestinal:	Enuresis; encopresis; emotional problems; parasites
Genitourinary:	Infections; medica problems; trauma; structural abnormalities.
Genital Tract:	Infections; congenial structural abnormalities.
Musculoskeletal:	Orthopedic or muscular problems; medical problems.
Endocrine:	Thyroid disease; diabetes; pituitary problems; adrenal disease.

Hematopoietic:	Anemia; leukemia; lead poisoning; idiopathic thrombocytopenia, sickle cell disease; thalassemia.
Neurological:	Medical problems; learning/behavior disorder.

FAMILY MEDICAL HISTORY

This information relates to immediate family members and relatives,ie., aunts, uncles, grandparents, parents, siblings. Diseases listed tend to have a genetic component and are included because they may have both a physical or emotional implication for the child. A family member with a chronic illness has implications for altered family relationships, financial state, stresses and coping of individuals and the family unit. A family history of diabetes and hypertension may have future implications for the child. History of a particular disease/disorder can have psychological implication and need for referral either for the child or for the family unit.

FAMILY BACKGROUND DATA

Current research data indicates a significant incidence of similar learning difficulties among family members.

SOCIAL DATA

This section is very important in the overall assessment of the child. It must be recognized that some questions are extremely sensitive in nature and that we must recognize that sensitivity.

Information about change within the family constellation offer clues to family support systems. An extended family may provide additional emotional and/or financial support to family members or a child who has lived in multiple foster homes may have difficulty forming trust and long-lasting relationships. Divorce, remarriage and/or single parent households may also have potentially detrimental emotional effects.

The identification of alcohol/drug/physical/sexual abuse affects the abuser as well as every member of the household. Most often a family member will discuss his/her perception of the problem and how it affects familiar relationships and communication. Its effects on children/family are becoming well documented in its impact on the stability/emotionality of the child and the child's health status.

If a family is being serviced by community or private agencies, it is helpful to know which one(s). Such information may be useful for further reference or for making apparent what problems have/have not been currently addressed.

SUMMARY

An overall medical/emotional/social "picture" of the child may be drawn from data collected during this health history. This data will help in identifying important data for the formulation of a nursing care plan or an IFSP.