



Family Serial no: _____

Place family picture

Name of Mother: _____ Blood Type: _____

Educational Level: _____ Occupation: _____

Name of Father: _____ Blood Type: _____

Educational Level: _____ Occupation: _____

Name of Child: _____ Birth date: _____

Philhealth Card No.: _____

Address: _____

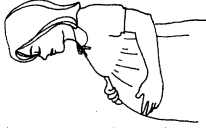
(House No.) Street Purok Barangay Municipality/City/Province



Health Record During Pregnancy

This pregnancy is special, so I will make sure that I get the best care for me and my unborn child. Here are some important information regarding my health:

Age (yrs. old): _____ Weight (Kg): _____
 Height (Cm.): _____ Body mass index: _____
 Last menstrual period: _____ Expected date of delivery: _____
 Age of pregnancy: _____ This is my: _____ pregnancy
 (number)



Previous Pregnancies	1st		2nd		3rd		4th		5th		6th	
	Re-mark	Date	Re-mark	Date	Re-mark	Date	Re-mark	Date	Re-mark	Date	Re-mark	Date
Normal (N) or Caesarean Section (CS)												
Miscarriage (Y/N)												
Stillbirth (Y/N)												
Bleeding during pregnancy or after delivery (Y/N)												
Assisted delivery (forcep. etc.) Specify												
Child still alive (Y/N)												

*Remarks-i.e., N for Normal or CS for Caesarean Section; Y for Yes or N for No; specify if under Assisted Delivery like Forceps



Present Pregnancy

Trimester/Month	1st			2nd			3rd		
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Date of visit									
Weight in kg.									
Blood pressure									
Temperature (°C)									
Height of abdomen (in cm)									
Fetal heartbeat (per minute)									
Vaginal bleeding (Y/N)									
Urinary Tract Infection (Y/N)									
Pallor or anemia (Y/N)									
Abnormal presentation (Y/N) (not head presentation)									
Swelling of face and hands (Y/N)									
Vaginal infection (Y/N)									
Lab. test results (e.g. Hgb, urine, RPR (Rapid Plasma Reagin), blood film for malaria parasites, Hep B screen- ing)									



Warning Signs During Pregnancy

If I experience any of the following warning signs, I should immediately seek consultation in a health facility. Put a check (✓).

- Swelling of the legs, hands and/or face
- Severe headache, dizziness and blurring of vision
- Vaginal bleeding or vaginal spotting
- Pallor or anemia
- Fever and chills
- Vomiting
- Fast or difficult breathing
- Severe abdominal pain
- Vaginal discharge and/or genital sores
- Painful urination
- Watery vaginal discharge
- Convulsions or loss of consciousness
- Absence of/ reduced fetal movements

(less than 10 kicks in 12 hours in the second half of pregnancy)





Past and Present Illness/Health Problems

Please put a check (✓) on the appropriate column

Health Problems/Illness/Unhealthy Lifestyle	YES/ NO		Family History		Remarks
	Y	N	Y	N	
Tuberculosis (14 days or more of cough)					
Heart Diseases (shortness of breath)					
Diabetes (high blood sugar)					
Hypertension (high blood pressure)					
Bronchial Asthma					
Urinary Tract Infection					
Smoking					
Alcohol Intake					
Malaria					
Parasitism					
Goiter					
Anemia					
Tooth Decay/Gum Disease					
Genital Tract Infection					

Immunization Record

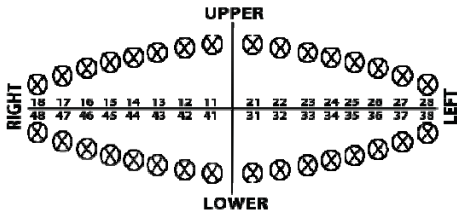
Tetanus Toxoid Immunization	Date Given	When to Return
1 st dose – as early as possible during pregnancy		
2 nd dose – at least 4 weeks later		
3 rd dose – at least 6 months later		
4 th dose – at least 1 year later		
5 th dose – at least 1 year later		
Other Vaccines (specify)		
Fully Immunized	[] YES [] NO	



Be sure to get the complete 5 doses of tetanus toxoid for your lifetime protection against tetanus. This will also protect the baby in your womb (and your future babies) against neonatal tetanus.



Oral Health Condition



Legends: Permanent ✓ D F M Un JC Legends: S - PF - TF - X - O -	Tooth Condition Sound Decayed Filled Missing Unerupted Jacket Crown Sealant Permanent Filling Temporary Filling Extractor Others
---	--

A. Check (/) if present (X) if absent	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Date of Oral Examination									
Dental Caries									
Gingivitis/Periodontal Disease									
Debris									
Calculus									
Abnormal Growth									
Cleft Lip/Palate									
Others (supernumerary/mesiodens, etc)									

B. Indicate Number									
No. of Perm. Teeth Present									
No. of Perm. Sound Teeth									
No. of Decayed Teeth (D)									
No. of Missing Teeth (M)									
No. Filled Teeth (F)									
Total DMF Teeth									
Services Rendered									

Remember this:

- It is not true "one tooth is lost with every pregnancy". Increase in hormones during pregnancy result in increase in the amount of plaque on your teeth. If the plaque is not removed, it can cause red swollen, tender gums that more likely to bleed.
- Brushing your teeth after each meal will prevent this.
- Eat nutritious foods rich in calcium (milk, cheese, seafood) Vitamin C (fresh fruits), vegetables & B12 (meat, nuts) to help keep your teeth and gums healthy and strong.



	MONTHS								
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Iron Folate (and other Micronutrient Supplements)									
Check for STI/HIV/AIDS									
Dental check-up									
Hepatitis B Screening									
Breast examination									
Sputum exam (if with signs/symptoms of tuberculosis, cough more than 14 days)									
Advise on newborn screening, breastfeeding, proper nutrition and reduced work load									
Counselling on FP (eg., spacing for the next pregnancy and limiting pregnancies to achieve desired family size)									
Deworming									
Malaria prophylaxis (endemic area)									
Other services, specify (including Pap Smear)									
Date of next visit									

*Refer to HIV Counseling and testing if (+) risk or Syphilis/STI

* Routine risk assessment


___ Have you or your sex partner had sex with more than one person in the past three months?

___ Did you or your partner ever inject illicit drugs?

___ Did you or your partner have or in the past suffered from symptoms of STI (genital tract symptoms, such as dysuria, discharge or sores)



Other Problems Identified and Actions Taken	Date	Problems	Action Taken

 It is important to begin care as early in pregnancy as possible. Visit the health center at least 4 times during the pregnancy, even if you do not have any problem.



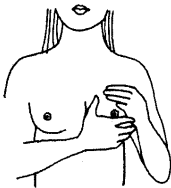
Some Helpful Tips I Should Remember



I will eat a balanced diet and increase my intake of food for energy/ carbohydrates, protein, Vitamin A, folic acid and other nutrients.



I will practice oral and personal hygiene. I will visit my dentist regularly.



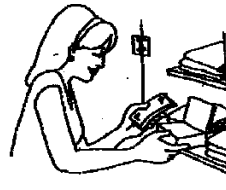
I will start breast care in preparation for breastfeeding.



I will not resort to self medication for this can harm me and my baby



I will make sure to receive tetanus toxoid immunization to protect myself and my baby



I will prepare for possible emergency (money, blood donor, transportation, screenings for newborn, Hep B, and hearing, and other necessities).



I will sleep inside a treated mosquito net every night if I live or travel in malaria endemic area.



I will have counseling on FP to space my next pregnancy or stop getting pregnant for I have achieved my desired family size.



My Development Inside My Mother 's Womb



Mama, this is your month by month guide on how I am growing inside you. Anything you eat or do may affect my growth and development.

0-4 weeks



I already have the beginnings of my brain, a simple spinal cord and marks where my face will be. I measure about 2mm in length. ***Look at beautiful scenes and pictures. Avoid any medications or drugs that may affect me.***

4-8 weeks



My heart begins to beat around six weeks, and all the other organs start to develop. Facial bones forms, my eyes and eye color develop, and my fingers and toes appear. ***Listen to sweet and soothing music. You need to eat food rich in protein, calcium, iron, zinc and folate. What you will eat also provide nutrients for me. However, do not eat more than you should or you may gain excess weight.***

8-12 weeks

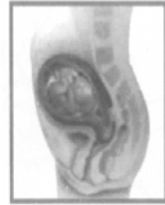


My major organs are now formed. My head is larger in proportion compared to the rest of my body to accommodate the rapid growing brain. I have a defined chin, nose and eyelids. I float in the amniotic fluid. I will be kicking gently. ***Don't forget to take your iron with folate supplements daily. Take time to relax and have some fresh air. Avoid salty foods as this will cause swelling around your feet, ankles and fingers.***



12-16 weeks

My legs are longer than my arms. My lungs are developing and my heartbeat can be heard by ultrasound. I have facial expressions, and eyebrows and eyelashes grow. I can turn my head and open my mouth. The hair on my head coarsens and develops its color. ***Consult a health worker right away if you have some health problems. Eat a well-balanced diet.***



16-20 weeks



I am more coordinated now, although my growth has slowed a little. I can suck my thumb and I respond to the sound of your voice. My taste buds develop and I can differentiate between sweet and bitter flavours. I am developing fingerprints and my body is covered with fine hair called “*lanugo*.” ***Talk to me. Play beautiful music and promise to give me breast milk. Take regular light exercises.***

20-24 weeks

My body is still thin, but now in proportion with my head. My bone centers are hardening. My genitals are developed, my nostrils open, and I make breathing motions. I have developed sleep patterns. Take a rest, as I would like to rest too. ***Talk to me at least 15 minutes daily. Let me feel your love for me. Listen to sweet and soothing music everyday.***





24-28 weeks



I am now preparing myself for birth. Fat builds up under my skin, my head hair grows, my eyelids open and my brain is more active. I can hear a lot now, including internal and external noises. I can recognize your voice, and my heartbeat will quicken when you speak.

Take care because I want to be born as a full term baby. Please reduce your work load and start eating calorie in addition to protein-rich foods.

28-32 weeks

I am now perfectly formed. I can see light through your abdominal wall, making me blink. I move around less as I put weight. My lungs are not fully mature yet, but I have a good chance of survival if I am born now. ***Let Dad touch your abdomen and tell him to talk to me.***



36 weeks



I am ready for birth by practicing my breathing, sucking and swallowing. The fine downy hair on my body has gone. My intestines are filled with meconium (first bowel movement) which I will pass in the first two days after birth. My head has now dropped into your pelvis ready for birth. It could be any day now.

Be sure that you are prepared for my coming.



Baby Care Routine

I am already advised on the following baby care routine:

- Keeping my baby warm, through skin to skin contact “kangaroo care” or wrapping him with a blanket immediately after delivery.
- I should wash hands thoroughly with soap and water before handling my baby and especially after changing diapers.
- Delay bathing my baby for at least 6 hours after birth
- Leave the cord uncovered until it dries. I will not put anything on the cord. The cord will come off approximately 7-10 days.
- I should immediately bring my child to the Health Center or hospital if the cord smells or navel turns red.
- I will keep my baby away from smoke and other hazardous substance.
- I should breastfeed my baby frequently and for longer periods.
- I will bring my baby to the hospital if:
 - My baby refuses to feed*
 - The umbilicus is red or draining pus*
 - My baby feels hot (temperature $\geq 37.5^{\circ}\text{C}$) or unusually cold (temperature $\leq 35.4^{\circ}\text{C}$) when touched*
 - Convulsions occur*
 - There is difficulty in breathing or fast breathing*
 - My baby has yellow soles, eyes or skin*
 - My baby shows less or no movement*





Birth and Emergency Plan

I know that any complication can develop during delivery. I know that I should deliver my baby in a health facility.

I will be attended at delivery by _____
(Name of doctor/nurse/midwife)

I plan to deliver at _____
(Name and address of hospital/maternity clinic/RHU/BHS)

This is a Philhealth accredited facility Yes No

The estimated cost of the maternity/newborn care package in this facility is _____
(inclusive of newborn care)

The mode of payment is _____

The available transport is _____

I have contacted _____ to bring me to the health facilities
(Name and contact number of vehicle's owner)

I will be accompanied by _____

and _____ will take care of my children/home while I am away.

In case of a need for blood transfusion, my possible donors with their addresses and contact numbers are:

Name	Address	Contact Number

In case of severe complications, I will be referred right away to:

Physician _____

Referral Hospital _____

Tel.No./Cell no. _____

I have set aside money for newborn screening Yes No

And screening for hearing impairment Yes No

In case of emergency, please notify:

Contact Person: _____

Address & Contact No.: _____

Finally, I will exclusively breastfeed my baby up to 6 months Yes No



Preparation for Giving Birth

I already made necessary preparations for giving birth. These are the things I will be using during delivery. I will not forget to bring this Mother and Child Book.

For Myself

1. Set of skirt and blouse or loose dress with front opening
2. Panties/ maternity bra
3. Bath robe
4. One set of casual clothes
5. Towel
6. Brush/comb
7. Maternity sanitary napkins
8. Shampoo/soap
9. Toilet paper
10. Toothbrush/toothpaste
11. Slippers

For my Baby

1. Baby blanket
2. Baby clothes
3. Cotton cloth or disposable diaper
4. Bonnet
5. Mittens or gloves
6. Socks
7. Mild baby soap
8. Baby towel

These are the things I prepared for my baby at home

- | | |
|-------------------------------|-----------------------|
| 1. Crib with mattress | 10. Waterproof sheets |
| 2. Baby pillows | 11. Baby tub/basin |
| 3. Mosquito net | 12. Cotton buds |
| 4. Soft wash clothes | 13. Soft towel |
| 5. Cotton balls | 14. Mittens or gloves |
| 6. Diapers (cloth/disposable) | 15. Baby clothes |
| 7. Baby blankets/sheets | 16. Bib |
| 8. Socks | |
| 9. Bonnet | |



Labor and Delivery



Initiation of breastfeeding and immediate skin to skin contact within 30 minutes after delivery will help establish breastfeeding and mother-to-child bonding.

I started to experience labor pains at _____(time) on _____ (date)

I delivered my baby alive on : Date of delivery: _____

Time : _____, Type of delivery: _____

Place of delivery : _____

Attended by: _____

Partograph use: _____(attach)

What I observed with my baby after delivery

Action Taken

- Spontaneously cried out _____
- Did not cry at once _____
- Normal breathing _____
- Abnormal breathing/not breathing _____
- Strong movement _____
- Weak/no movement _____
- Baby placed on my abdomen for skin to skin contact _____
- Baby started breastfeeding within _____ hours (ideally within 1 hour)
- Baby stayed with me all the time
- Eye drops given
- Vitamin K injection given

My Baby is:

Sex: _____ Birth weight: _____, Length: _____

Chest circumference: _____ Head circumference: _____



You can become pregnant within several weeks after delivery, if you have sexual relations, and is not breastfeeding exclusively.

If you have decided to plan your next pregnancy by spacing for 3 years or want to stop getting pregnant, avail the chosen FP method before discharge.

Talk to a health worker with your husband/partner, about choosing a family planning method, which best meets you and your partner's needs.

Family Planning

Date of Follow-up	Date of Visit	Prescribed FP method	Quantity given (if supply available in the facility)	Facility	Provider	Referred FP method not available in the facility	Previous FP Method Used (if any)	Presence of Partner Yes / No	REMARKS (if clients is referred to another facility, specify) (indicate schedule of VSC Services)



Postpartum Care Within 42 Days

Within 24 hours	Within 1 week preferably 2-3 days	At 4-6 weeks
<input type="checkbox"/> Rapid Assessment and Management of emergency signs (i.e. fast or difficult breathing, cyanosis, shock, bleeding, fever, severe abdominal pain, convulsions or severe headache)	<input type="checkbox"/> Physical examination	<input type="checkbox"/> Physical examination
<input type="checkbox"/> Vitamin A 200,000 IU cap (once within 4 weeks after delivery) (Y/N)	<input type="checkbox"/> Check vaginal bleeding/foul smelling discharge	<input type="checkbox"/> Iron/folic acid supplement
<input type="checkbox"/> RPR if not done during pregnancy	<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Check for danger signs
<input type="checkbox"/> Tetanus Toxoid if not yet given	<input type="checkbox"/> Iron folic acid supplement	<input type="checkbox"/> Counsel on nutrition and family planning
<input type="checkbox"/> Iron/folic acid supplementation (up to 3 months)	<input type="checkbox"/> Vit. A if not yet given	
<input type="checkbox"/> Counsel on nutrition, FP and birth spacing, newborn care, follow-up visits	<input type="checkbox"/> Check for breastfeeding problems	
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Check for danger signs - fever - urinary tract infection - perineal pain - anemia	

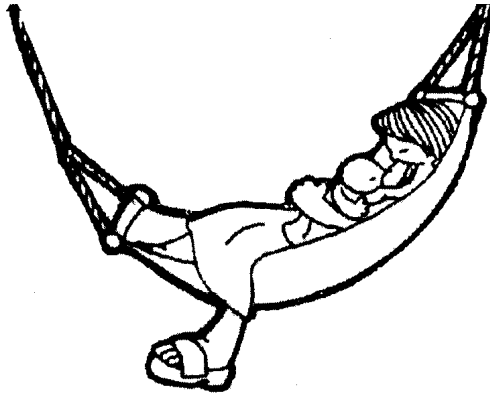
Date of Postpartum Care Check-up

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Other:



Take a bath daily. Change sanitary pad every 4 to 6 hours. You should be seen by a health worker 4 times after delivery based on the schedule above.

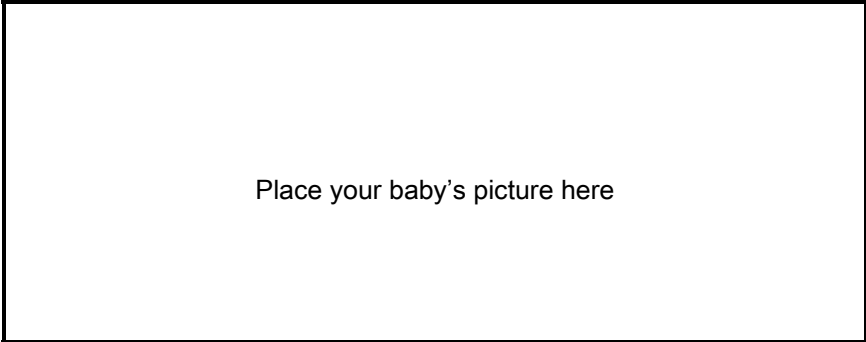


MOTHER' S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

1. The Right to Life
2. The Right to Liberty and Security of the Mother
3. The Right to Equality, and to be Free from all Forms of Discrimination
4. The Right to Freedom of Thought
5. The Right to Information and Education
6. The Right to Choose Whether or Not to Marry and Found and Plan a family
7. The Right to Decide Whether or When to have Children
8. The Right to Health Care and Health Protection
9. The Right to the Benefits of Scientific Progress
10. The Right to Freedom of Assembly and Political Participation
11. The Right to Be Free From Torture and Ill-Treatment
12. The Right to Development



My Birth Record



Place your baby's picture here

Name of Child: _____ Nickname: _____

Boy

Parent 's names:

Girl

Mother: _____

Father: _____

Type of delivery: _____

Date of Birth: _____ Gestational age at birth: _____

Single/multiple birth: _____

Place of delivery: _____

Attendant at birth: _____

Blood Type: _____

Birth weight: _____ Length: _____

Head circumference: _____ Chest circumference: _____

Birth order: _____

Birth registered on: _____ at: _____

Adverse event data (severe illness or death of parent, sibling < 5 years old, pls. specify _____)

(date) _____ (place) _____



Postnatal Care

Within 24 hours	1st week preferably 2-3 days	2-4 weeks	6 weeks
<input type="checkbox"/> Skin-to-skin contact/warmth <input type="checkbox"/> Breastfeeding initiation <input type="checkbox"/> Newborn assessment <input type="checkbox"/> Eye prophylaxis <input type="checkbox"/> Vitamin K <input type="checkbox"/> BCG <input type="checkbox"/> Hep. B	<input type="checkbox"/> Newborn assessment <input type="checkbox"/> Exclusive breastfeeding <input type="checkbox"/> Newborn Screening <input type="checkbox"/> Cord care <input type="checkbox"/> Hearing Screening	<input type="checkbox"/> Newborn assessment <input type="checkbox"/> Exclusive breastfeeding	<input type="checkbox"/> Infant assessment <input type="checkbox"/> Exclusive breastfeeding <input type="checkbox"/> Vaccination
Date of Postnatal Check-up			

Bring your baby to a health center as soon as possible if he/she has any of the following signs:

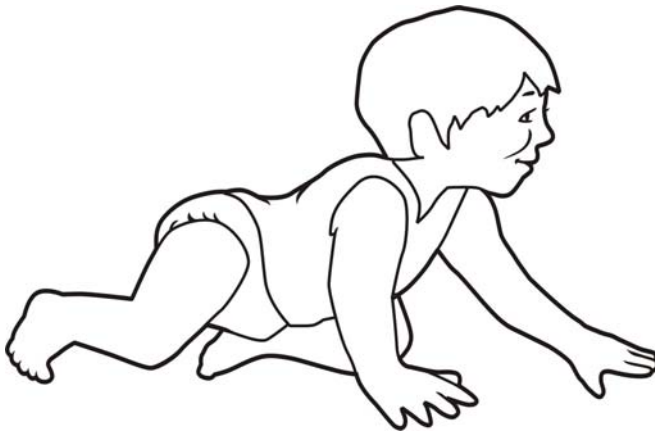
- Feeding less or not feeding at all
- Convulsions
- Fever
- Feels cold
- Inflamed cord with pus or blood
- Yellow sole, eye or skin
- No movement or less movement
- Pus in the eye and skin
- Fast or difficulty in breathing



This is my personal diary. It contains records of the essential health services I need for survival and growth. Important events and milestones in my growth and development should be recorded here.

*I have the right to a name
and nationality.*

*Register my birth at the
Local Civil Registry.*





What I Need During the First Few Weeks After Birth



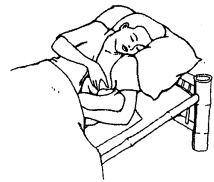
Always keep me warm. The best way is through skin-to-skin contact by placing me on your abdomen (before cutting the cord or on your chest after the cord has been cut). Cover me with soft cloth.

Make sure that eye prophylaxis is applied to my eyes to prevent infection and subsequent blindness.

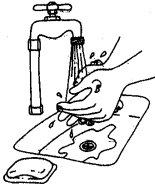


To keep me warm, immediately wipe and wrap me and delay bathing for at least 6 hours. Keep me always at your side or within your reach. Always keep me warm by wrapping me with a blanket. I love the way you keep me in your arms.

Start to breastfeed me within the first thirty minutes after birth and for as long as I want. This will help you produce more milk. I know that your breast milk alone is the best food for me up to six months of age. Do not give me any other formula or water, or semi-solid food.



If you have difficulty in giving me your breast milk, consult a health worker nearest you.



Take care of my cord.

Wash your hands before and after cord care.

Wash the cord only when soiled. Use boiled water that has been cooled and mild soap for cleaning.

Allow it to air dry. Do not wipe with any cloth to

avoid infection

Do not bandage my stump or abdomen. Do not apply any substance or medicine to my cord stump.



You should seek immediate care if my umbilicus is red or with pus or blood.



Bring me to the hospital for newborn screening after the 24th hour.

Date: _____ Health Facility: _____

Result: _____



Have your newborn screened for congenital metabolic disorders to prevent mental retardation and possible death.



My Immunization Record

Immunization protects me against several infectious diseases. If I am not immunized, I am more likely to get sick, become undernourished, become disabled, or die. All my essential immunization should be completed before my first birthday. Bring me to a health facility on the scheduled dates.

	*Within 24 hrs (at Birth)	6 weeks	10 weeks	14 weeks	9 months	12-15 months	16 months & above
BCG*							
DPT/Hep B-Hib (Pentavalent)							
OPV							
HBV*							
AMV (9 months)							
MMR							
Other vaccines Specify:							

Vitamin A Supplementation & Deworming

I should start Vitamin A supplementation when I reach 6 months and have Vitamin A supplementation every 6 months thereafter. My deworming should start when I am 12 months old and can be regularly dewormed every 6 months thereafter.

Date	6 months		1st year		2nd year		3rd year		4th year		5th year	
	1	2	1	2	1	2	1	2	1	2	1	2
Vitamin A												
Deworming												



Feeding Recommendations



From birth to 6 months of age, I should only have breast milk with no other food, including water. Newborns like me should be breastfed 10 to 12 times a day, or as often as I want, for around 15 minutes on each breast at each feeding.

From 6 months up to 12 months, I should be breastfed as often as I want, and to be given complementary foods to satisfy my needs. Give me adequate amount of *lugaw* with added oil or select from any of the following variety of foods:

- Mashed vegetables, *monggo*, potato or camote
- Pulverized roasted dilis or flaked fish
- Chopped meat or chicken
- Egg yolk
- Steamed tokwa
- Fruits like banana, mango, avocado with added oil or mayonaise



Give me foods 1 or 2 times per day after breastfeeding, gradually increasing to 3 times per day. I also need nutritious snacks like *taho*.



From 12 months up to two years, I still want to be breastfeed often. Give me adequate amount of family foods like rice, camote, potato, fish, chicken, meat, monggo, steamed tokwa, pulverized roasted dilis, eggs, dark green vegetables (malunggay), squash and fruits (banana, papaya). Add oil or margarine. Please feed me 5 times per day. I would prefer my own serving in a separate plate or bowl. Make my eating a pleasurable, and learning experience by being there with me.



From two years onwards, I can eat a variety of foods. Give me three meals per day from prepared family food. Give me nutritious foods between meals, such as boiled yellow camote, boiled yellow corn, boiled sab-a banana, taho, fruits, and fruit juice twice daily. Don't forget to give me at least a glass of milk daily.





Tips



Here are some tips for making eating time a learning time for your child :

- Name the utensils, foods and colors
- Show your child some things that are small and some things that are big
- Talk to your child about how to tell the taste of the food
- Let your child touch and pick up the food, but make sure the hands are clean.





GROWTH CHART

(Reference: WHO Child Growth Standards, Methods & Development, 2006)



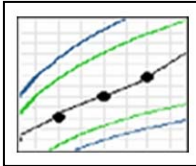
Checking My Growth and Development

I am a growing child. Please make sure that I grow and develop the way normal children of my age do. Keep track of my growth by having me weighed regularly— that is every month from birth up to 2 years of age and quarterly from 2 years to 6 years of age.

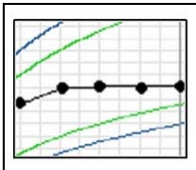
My weight as well as other important events should be plotted on the growth chart because these events may contribute to my losing or gaining weight.

On the growth chart you will see these events with their corresponding codes.

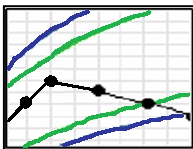
How to interpret my growth chart



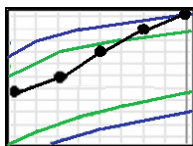
My weight should be between the “line ” curves. The plotted growth curve should go in upward direction. This means I am growing well!



I am not gaining weight or growing if plotted curve “flattens off” like this between the “line ” curves. My growth follows this pattern, if I have been sick or not getting enough food.



A plotted growth curve that goes downward or declining looks like this. This is a serious matter, so please bring me to a health facility or hospital.



If my plotted growth curve is going up like this, it means I am having a diet problem. Please talk to a health worker about how I can maintain a healthy diet.



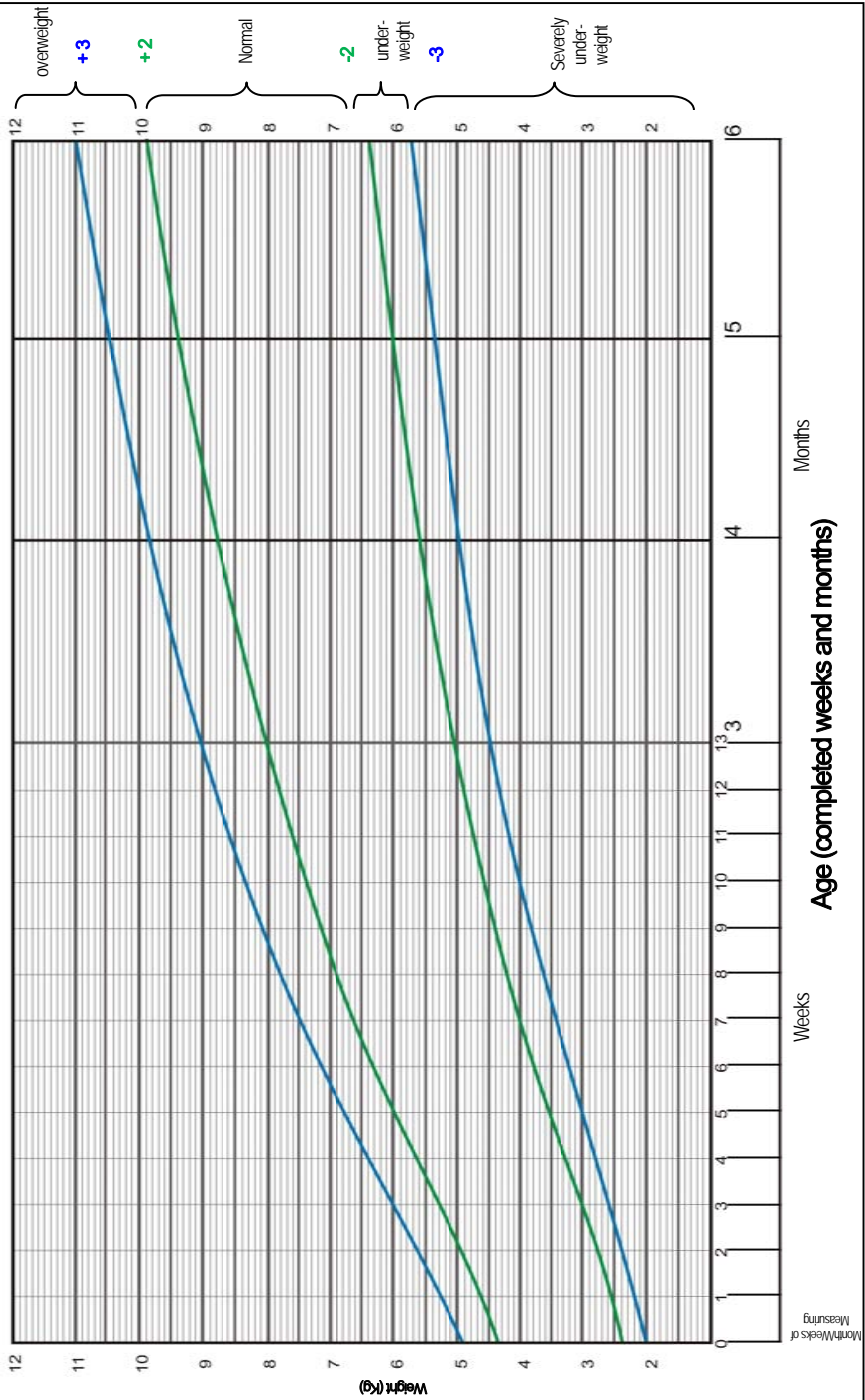
Symbols used in Growth Chart

Using the symbols below, a health worker will record relevant information or condition of your baby at the time of visit to the health center/clinic

- - Weight
- B - Breastfeeding
- CF - Complementary Feeds Introduced
- A - Vitamin A given
- EB - Exclusive Breastfeeding
- F - Fever
- C - Cold/Cough
- CP - Cleft Palate
- D - Diarrhea
- H - Hospitalized
- I - Injury
- O - Others

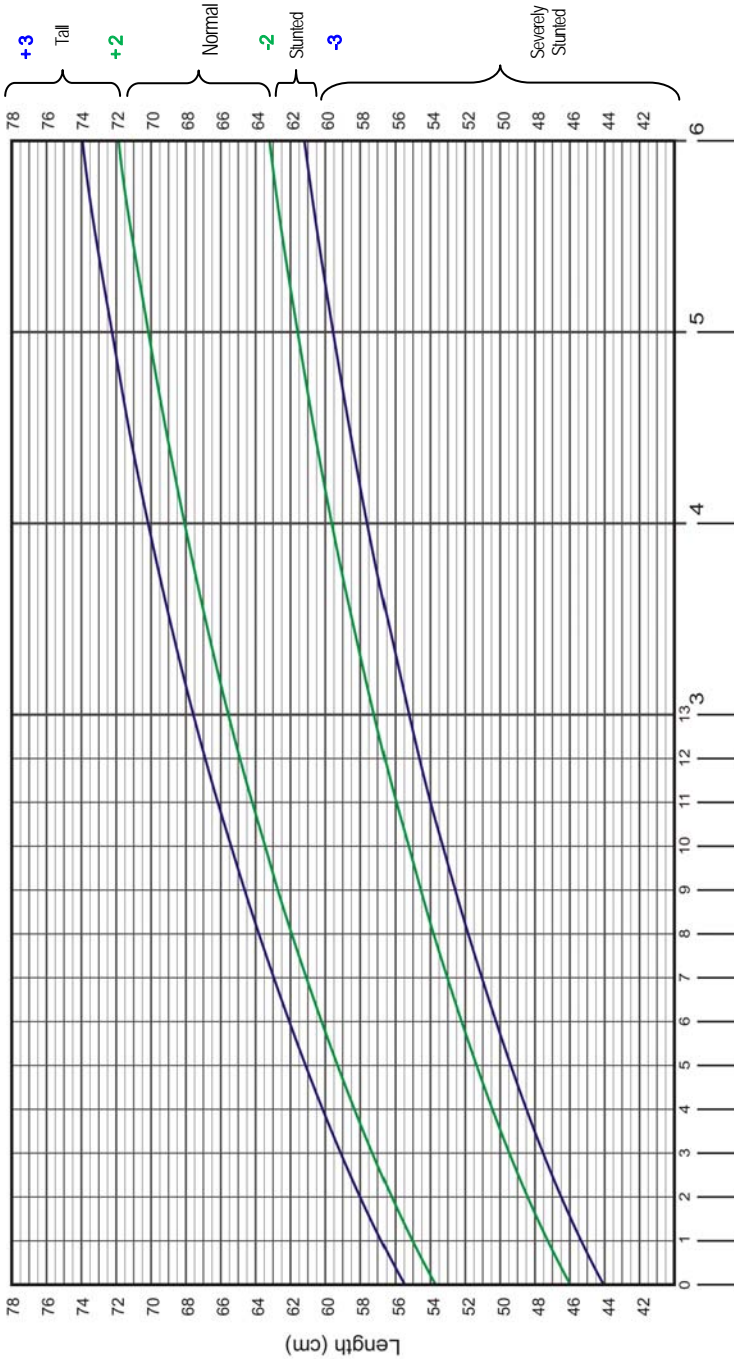


Growth Chart for BOYS: BIRTH to 6 MONTHS Weight-for-age





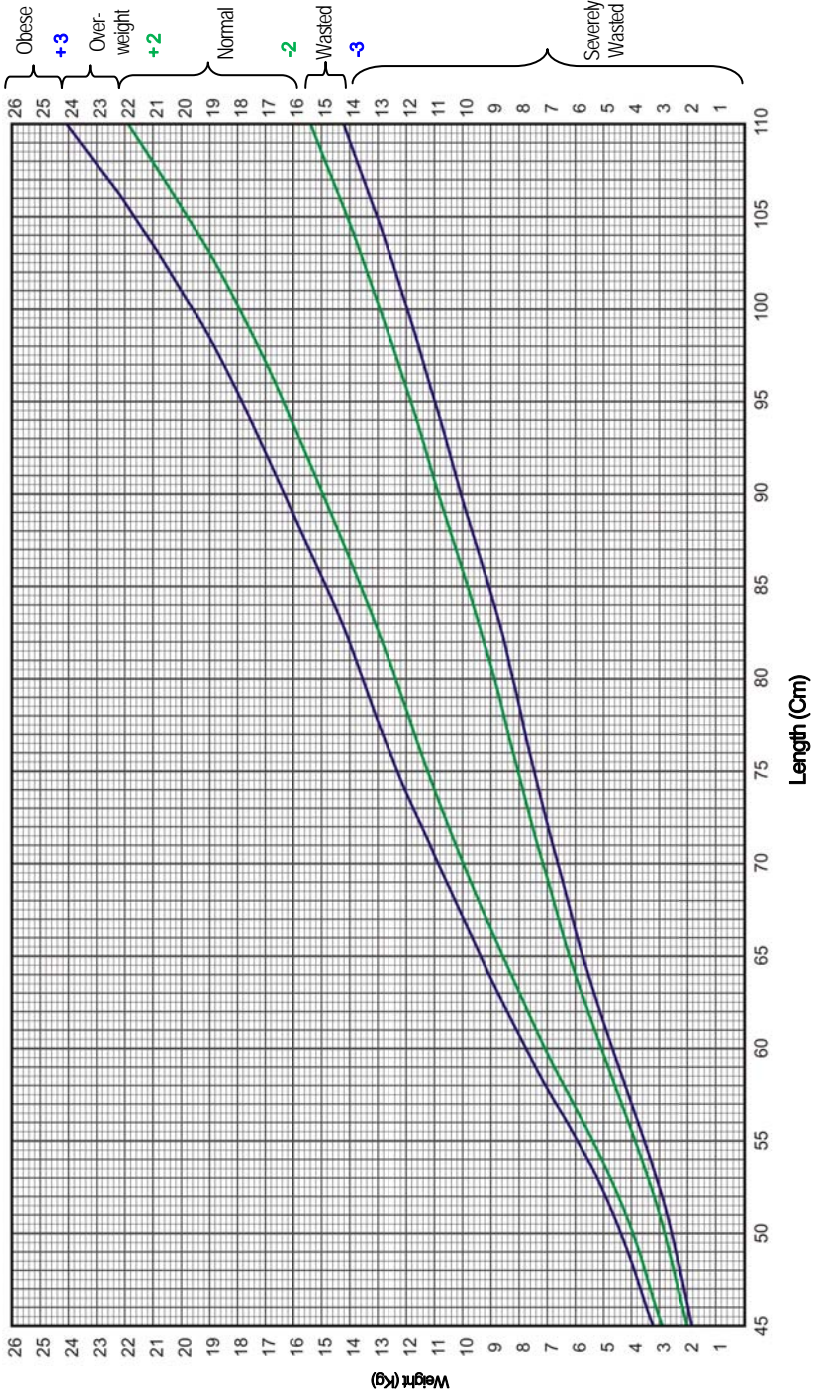
Growth Chart for BOYS: BIRTH to 6 MONTHS Length-for-Age



Age (completed weeks and months)

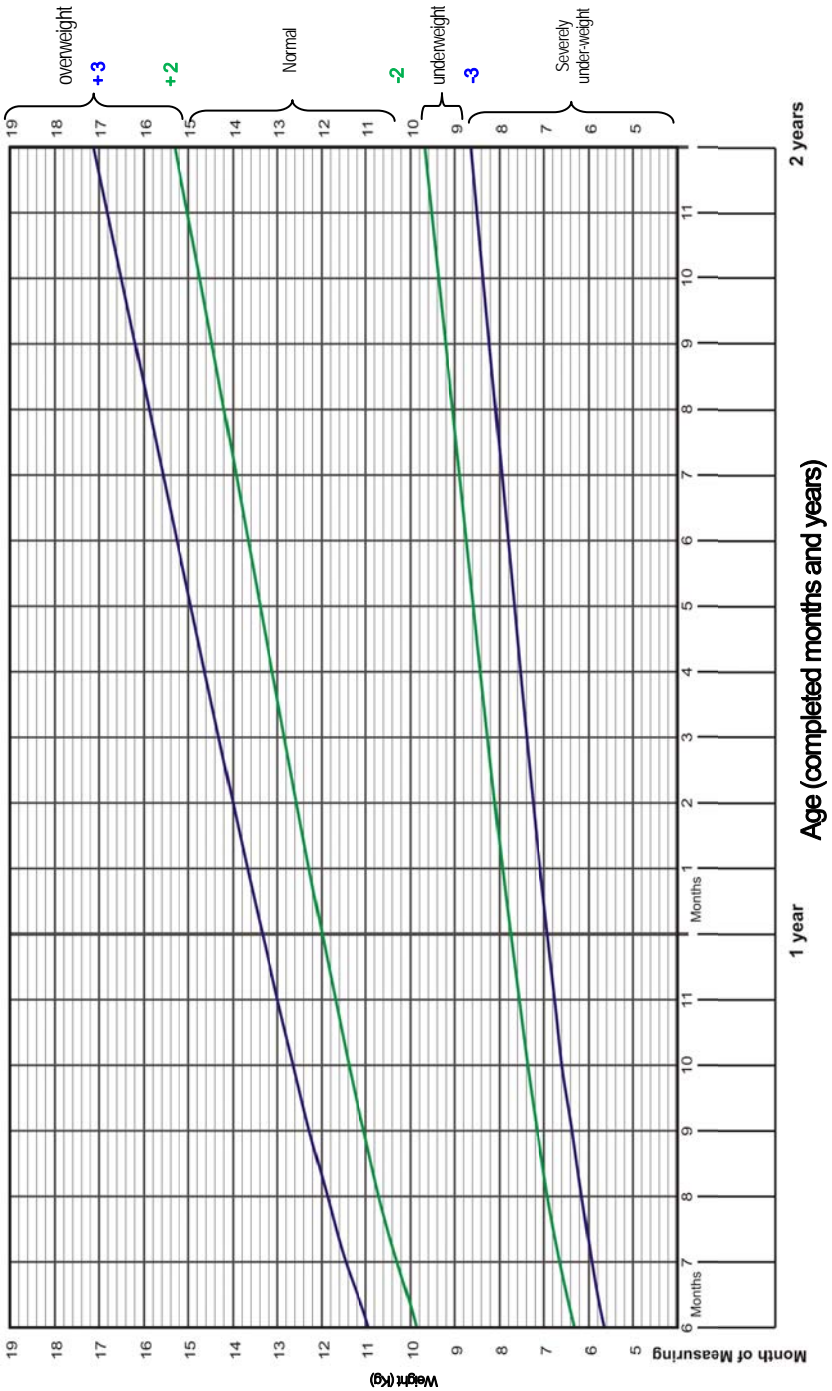


Growth Chart for BOYS: BIRTH to 24 MONTHS Weight-for-length



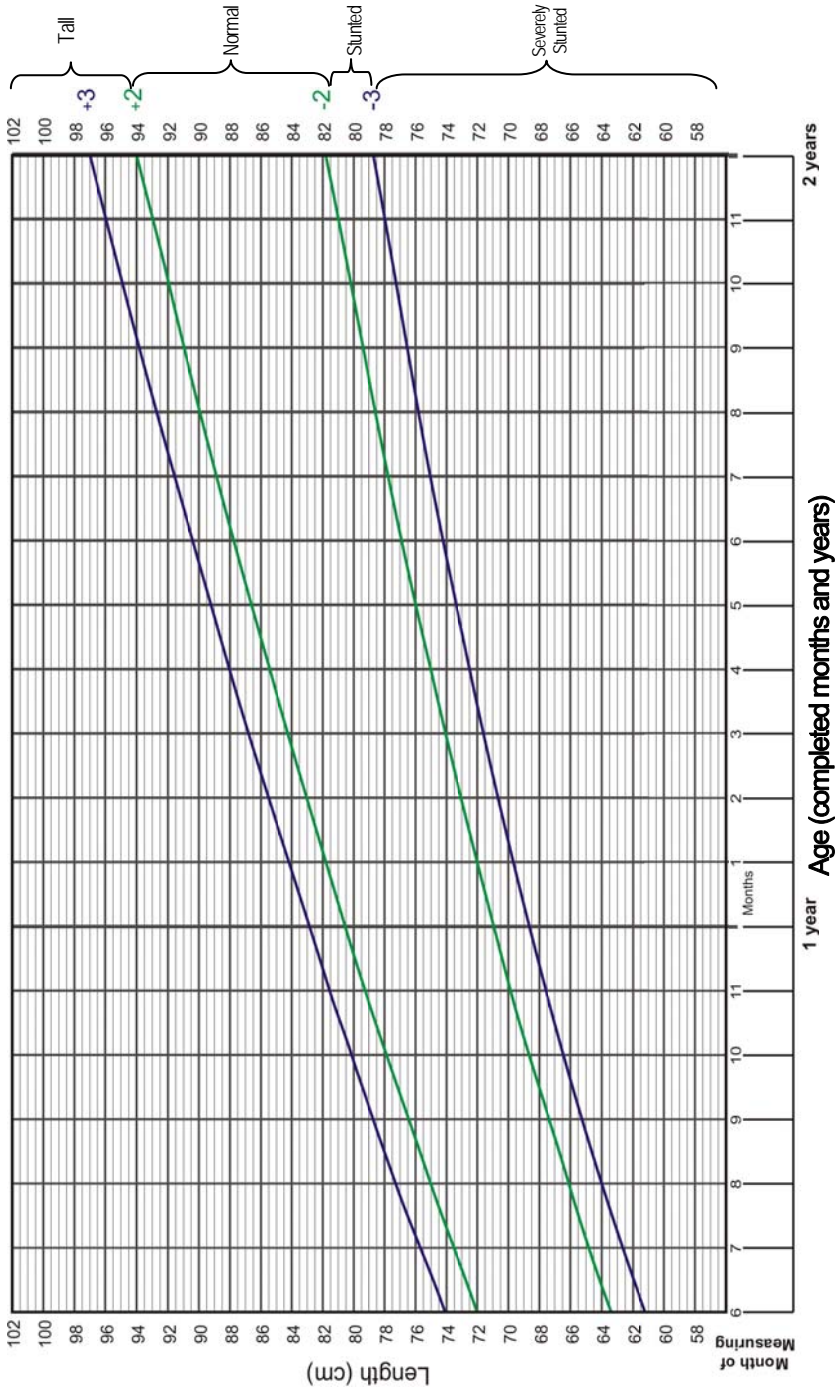


Growth Chart for BOYS: 6 to 24 MONTHS Weight-for-age



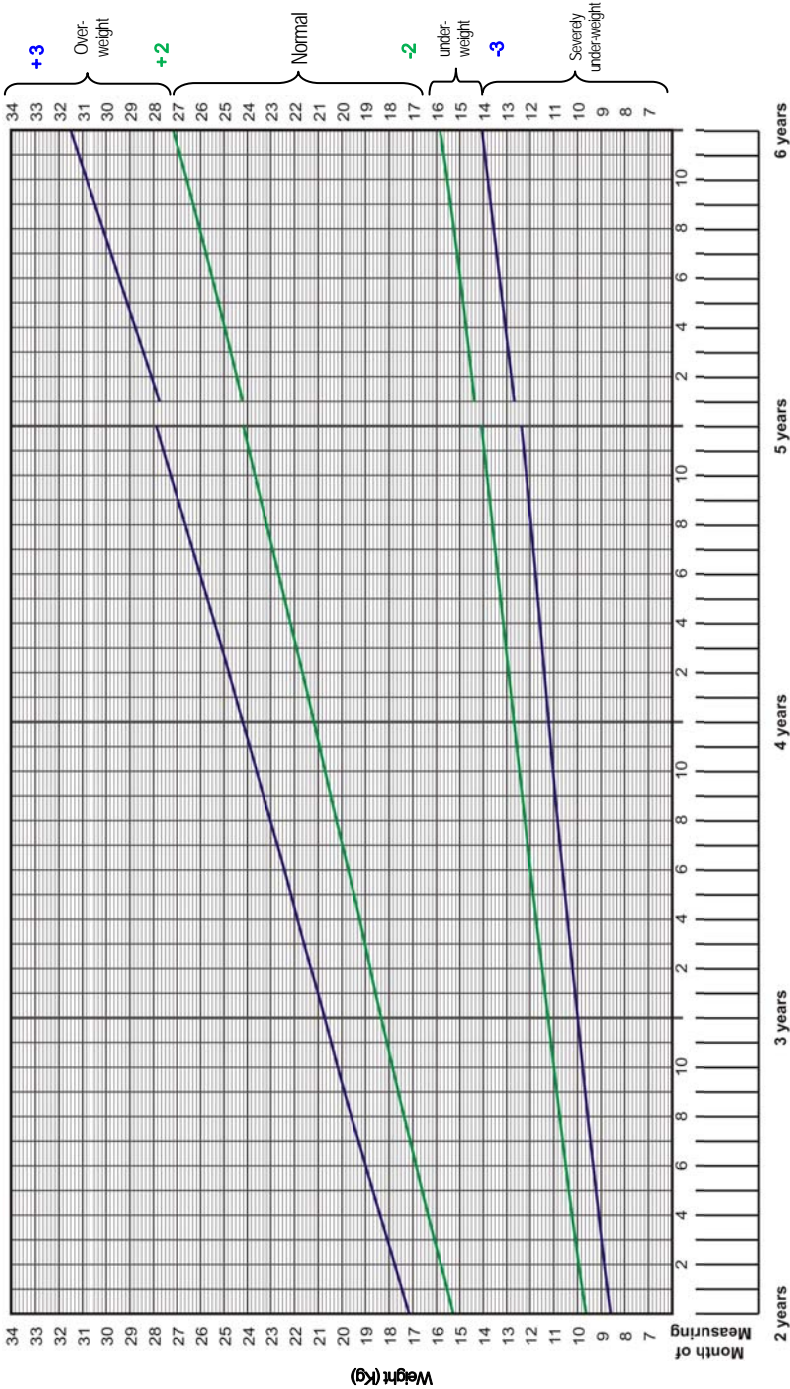


Growth Chart for BOYS: 6 to 24 MONTHS Length-for-age





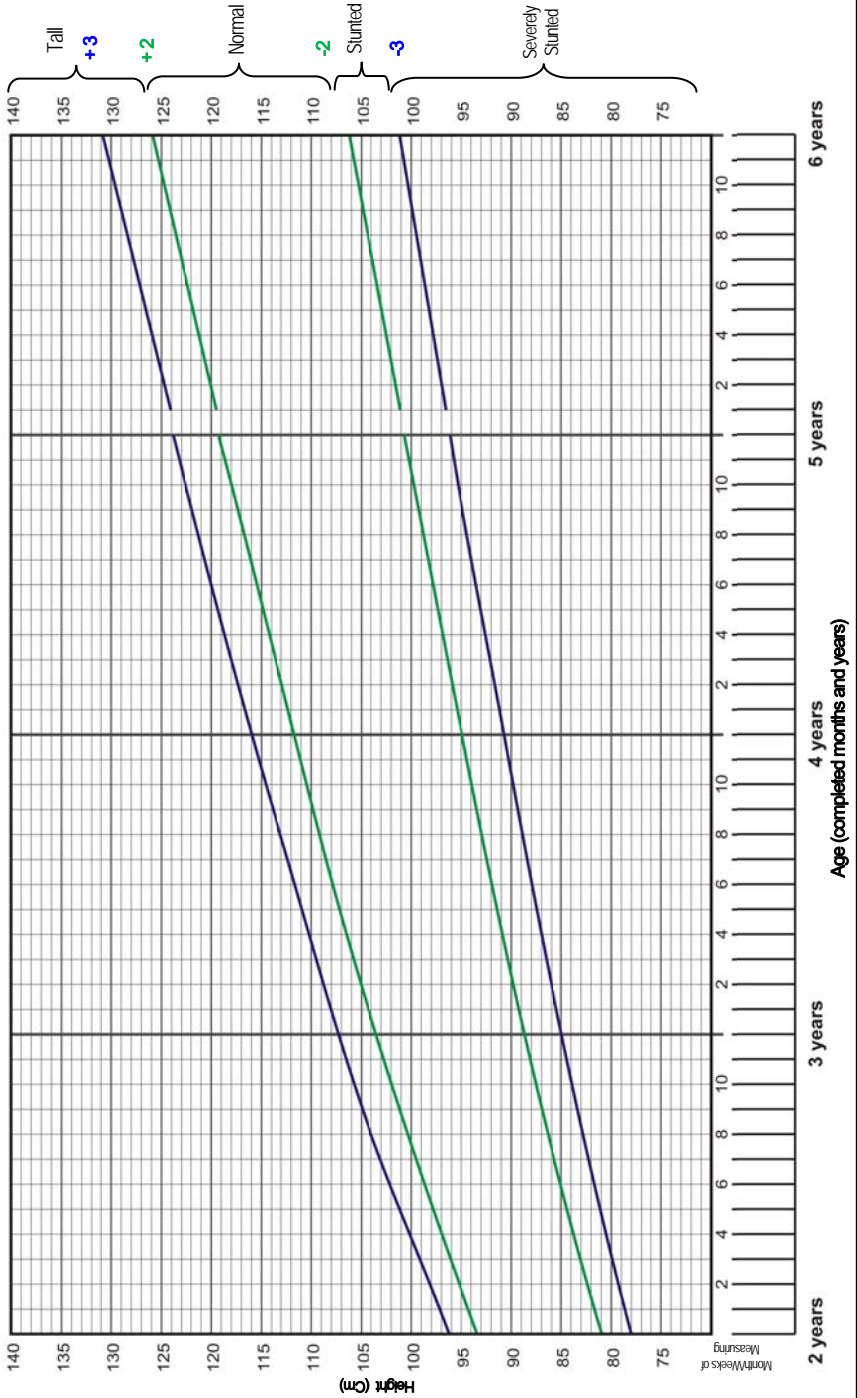
Growth Chart for BOYS: 24 to 71 MONTHS Weight-for-age



Age (completed months and years)

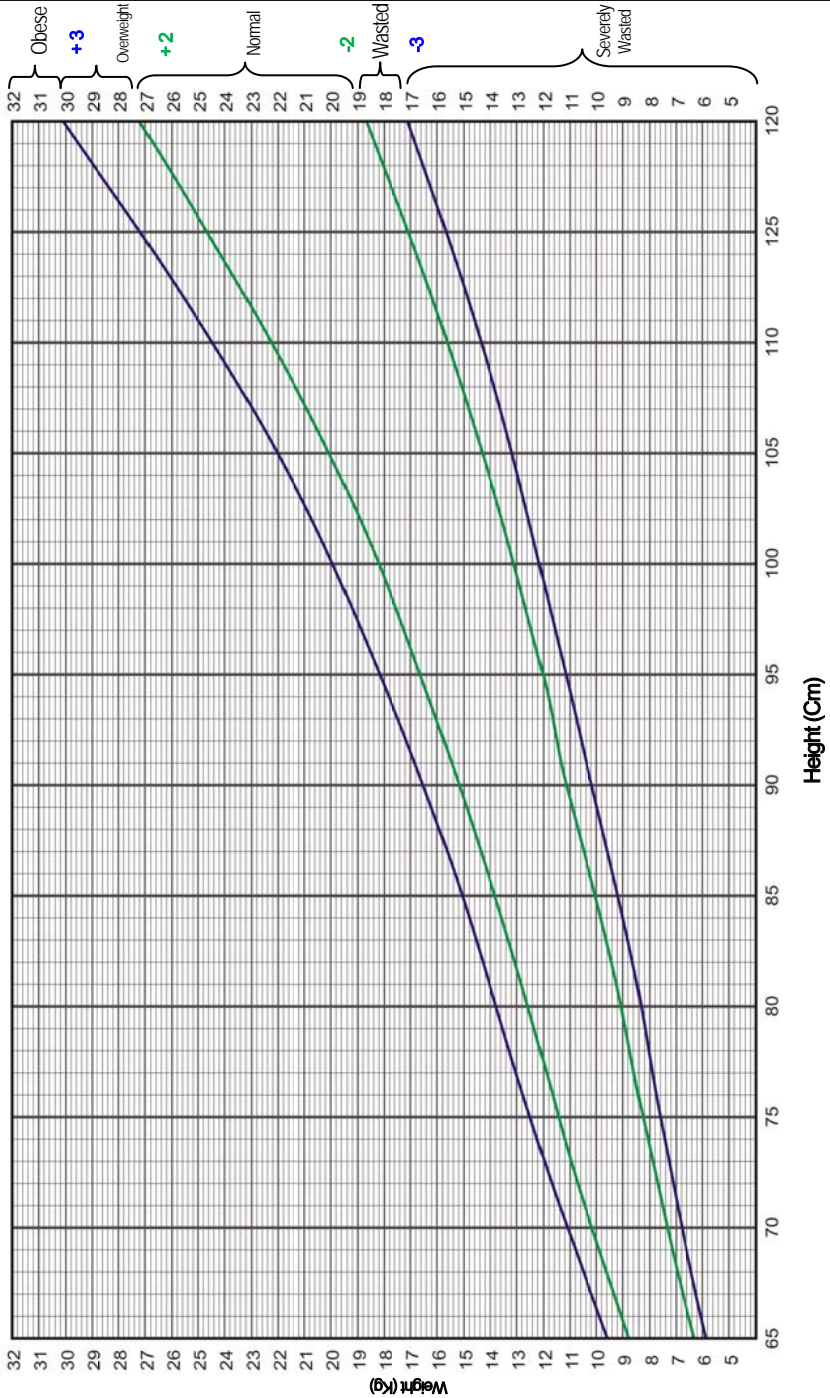


Growth Chart for BOYS: 24 to 71 MONTHS Height-for-age



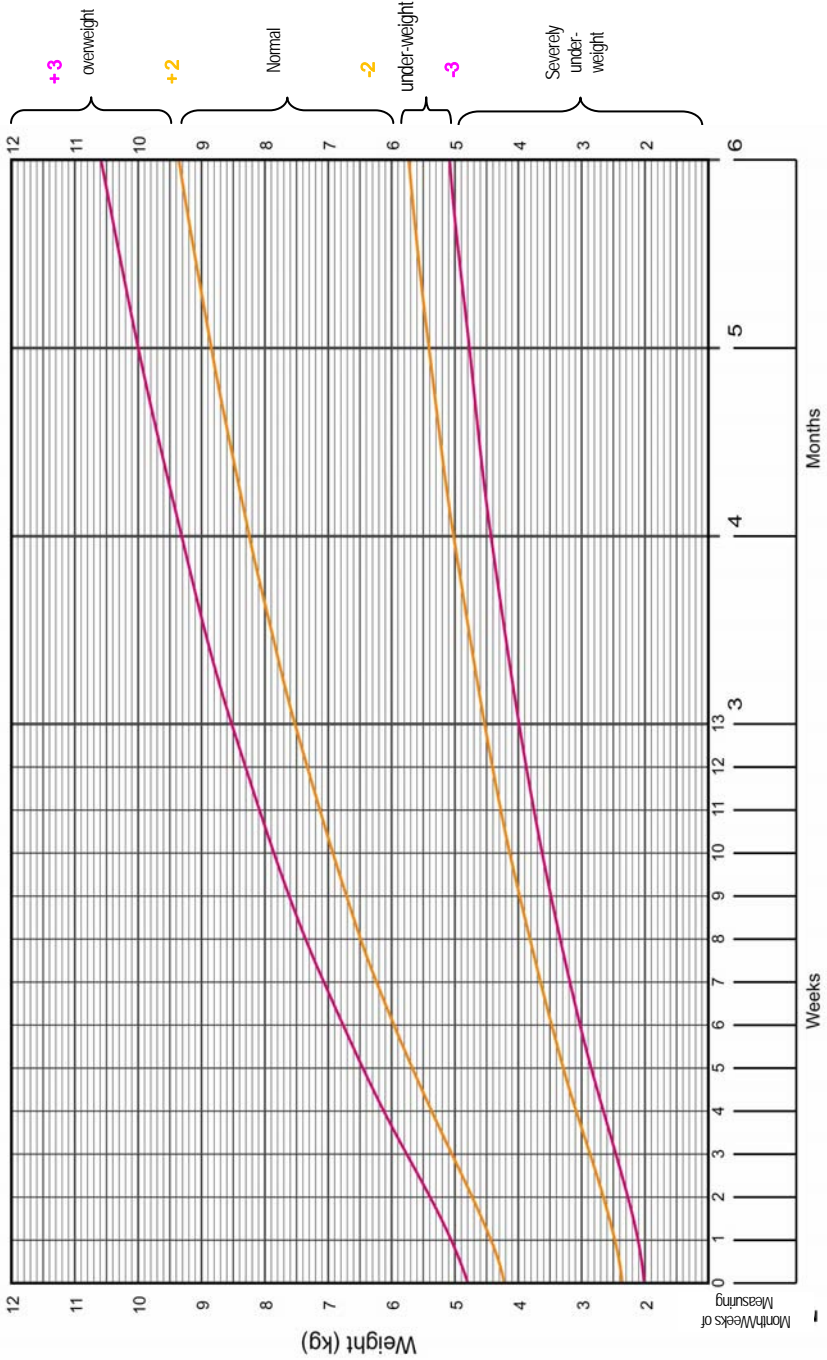


Growth Chart for BOYS: 24 to 71 MONTHS Weight-for-height



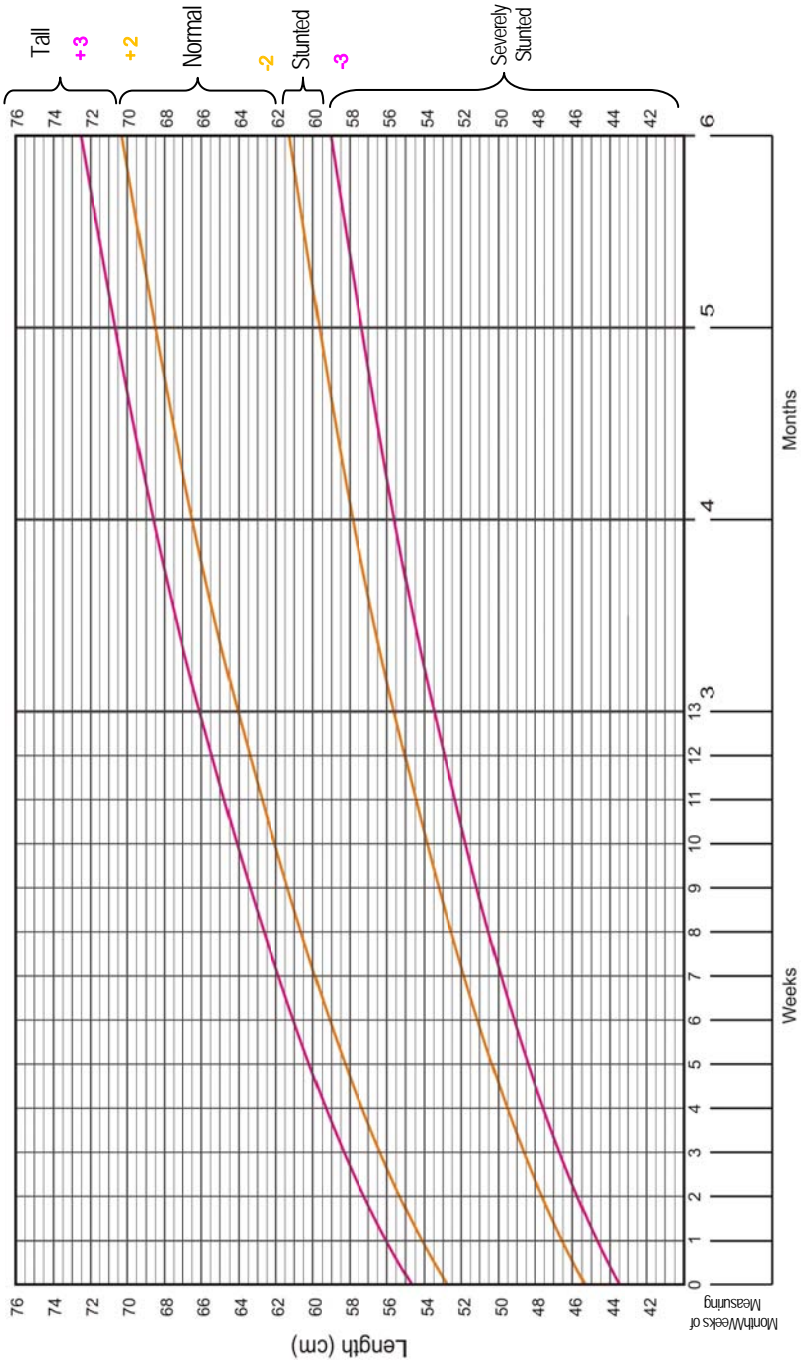


Growth Chart for GIRLS: BIRTH to 6 MONTHS Weight-for-age



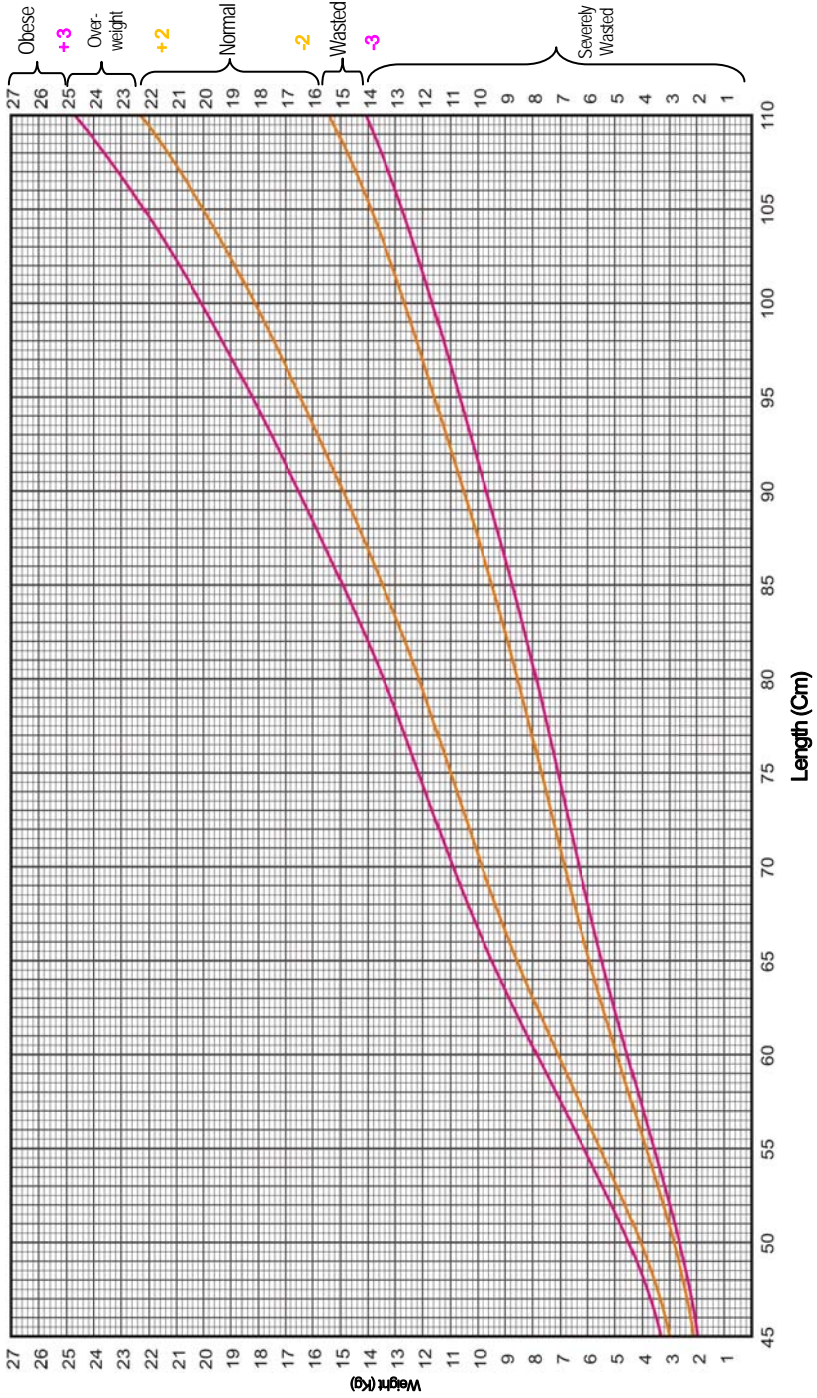


Growth Chart for GIRLS: BIRTH to 6 MONTHS Length-for-Age



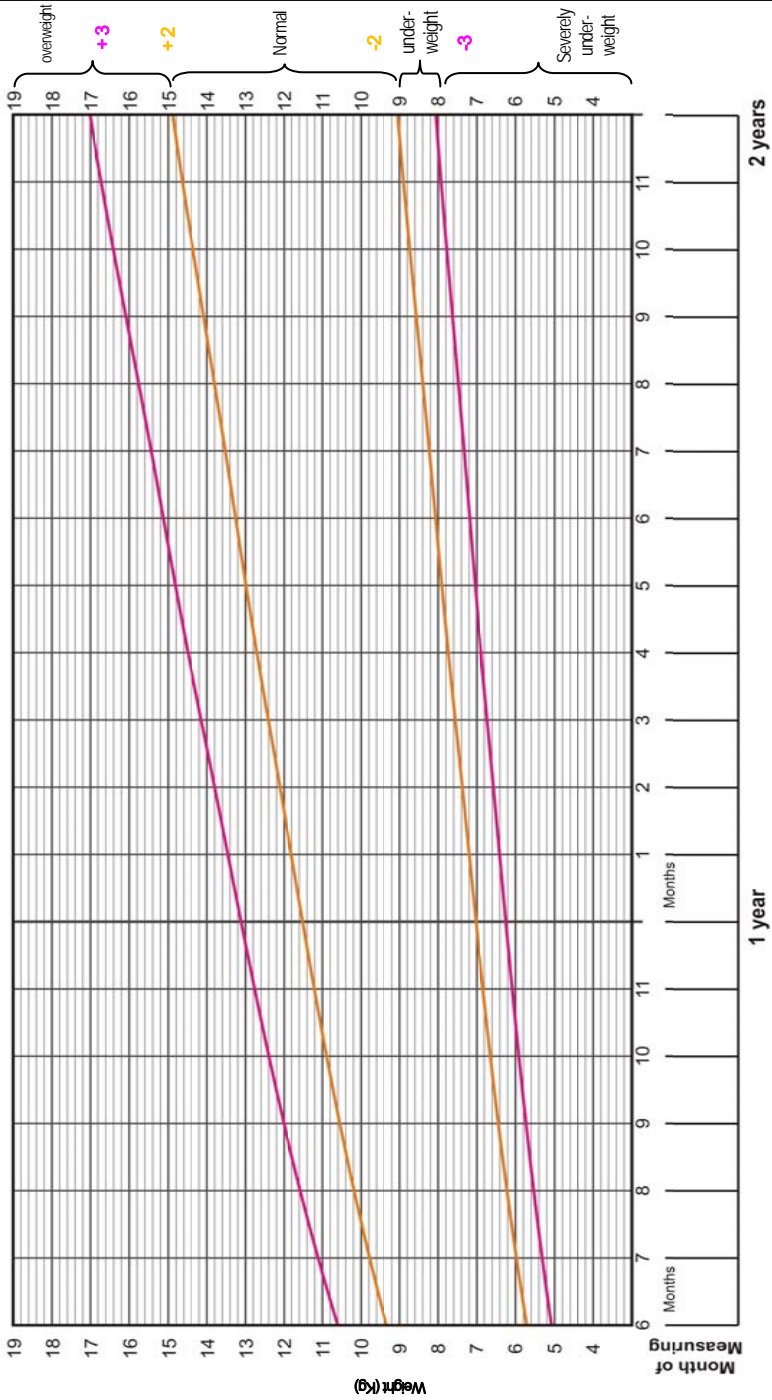


Growth Chart for GIRLS: BIRTH to 24 MONTHS Weight-for length



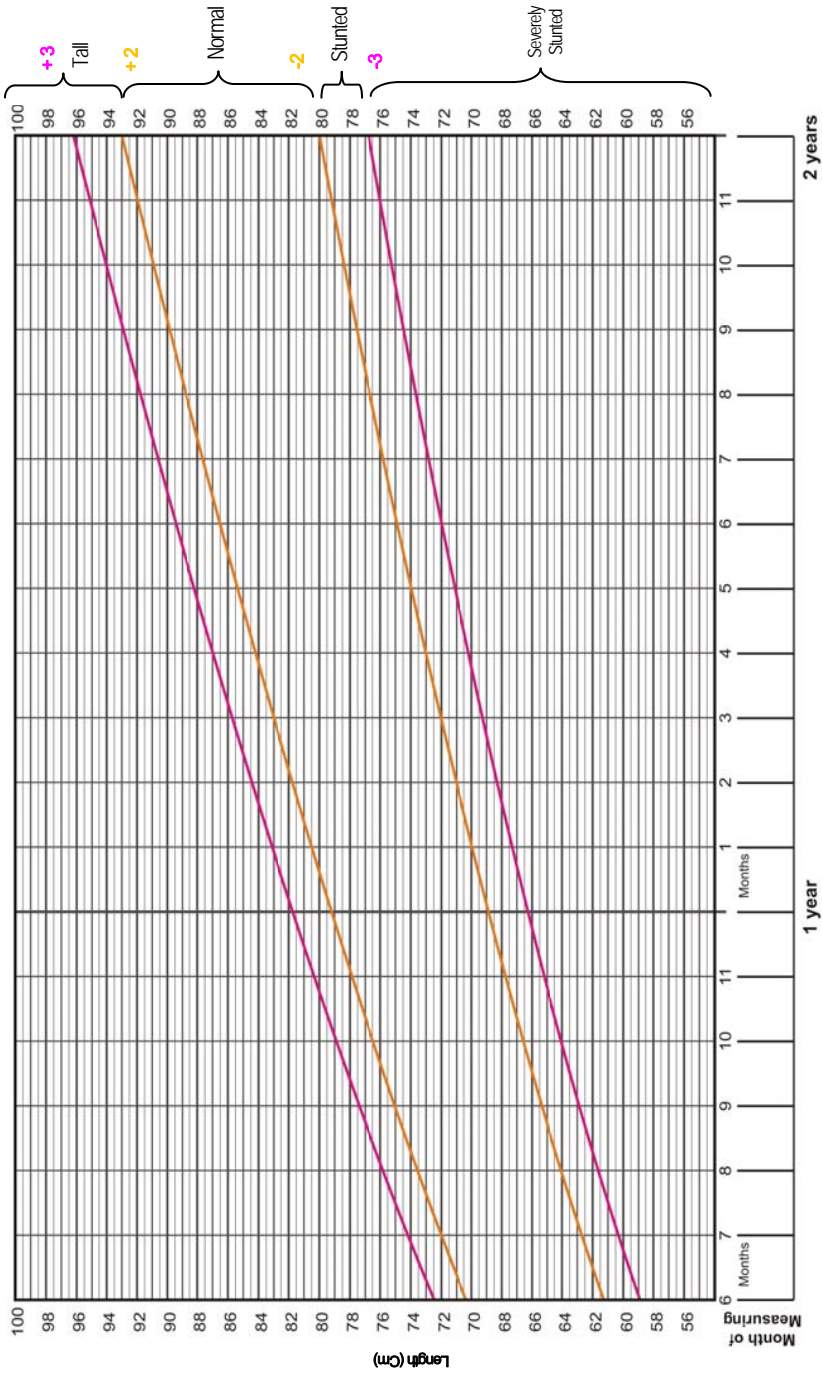


Growth Chart for GIRLS: 6 to 24 MONTHS Weight-for-age



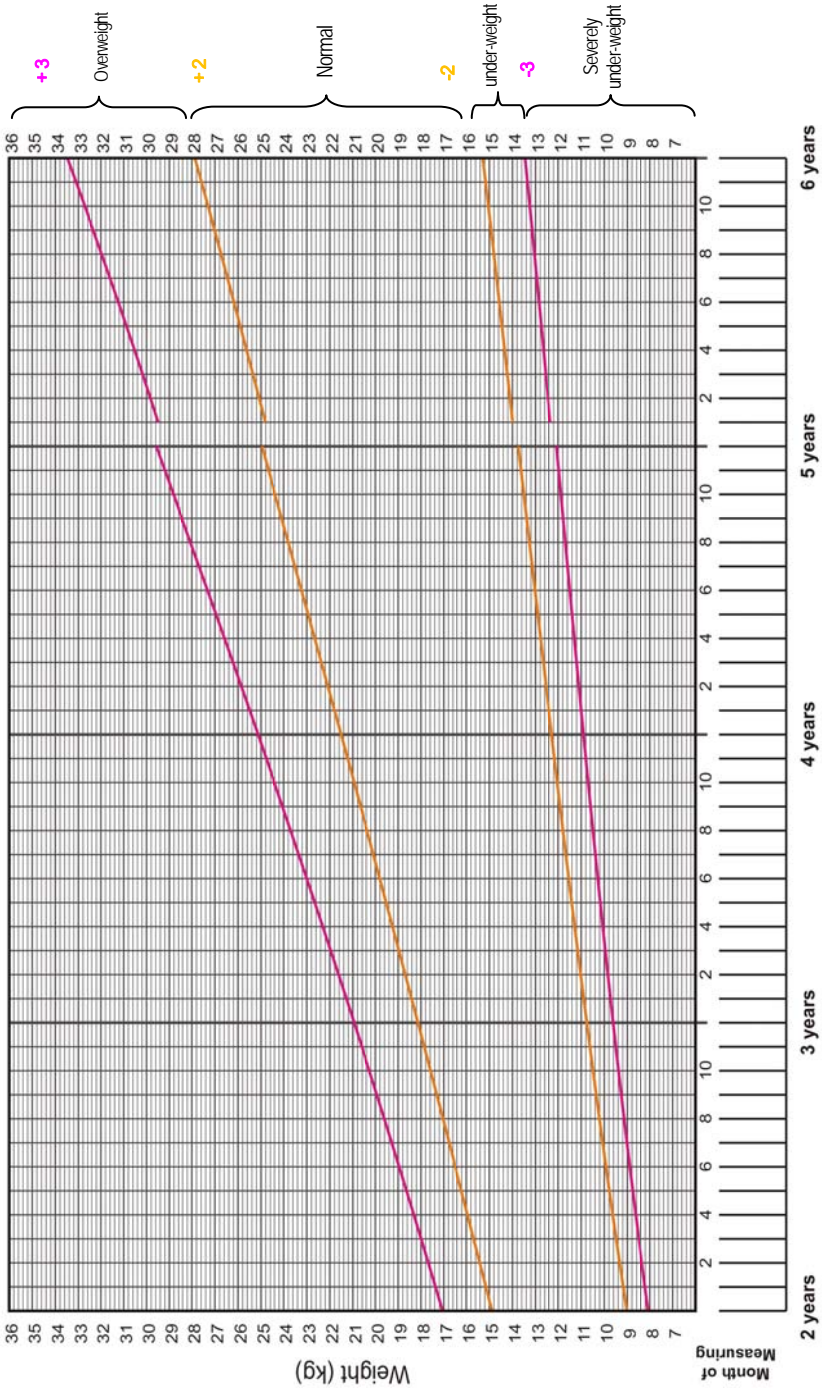


Growth Chart for GIRLS: 6 to 24 MONTHS Length-for-age



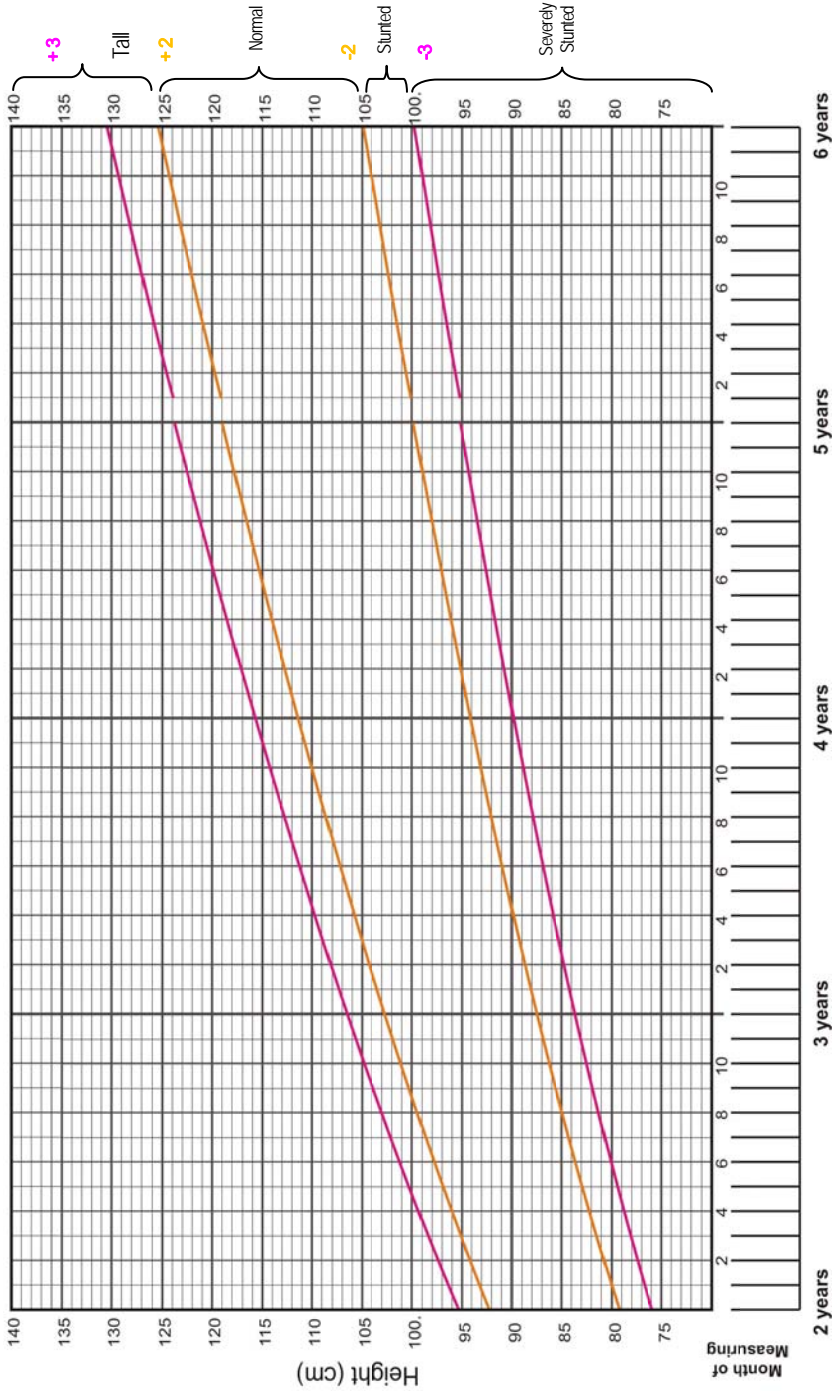


Growth Chart for GIRLS: 24 to 71 MONTHS Weight-for-age



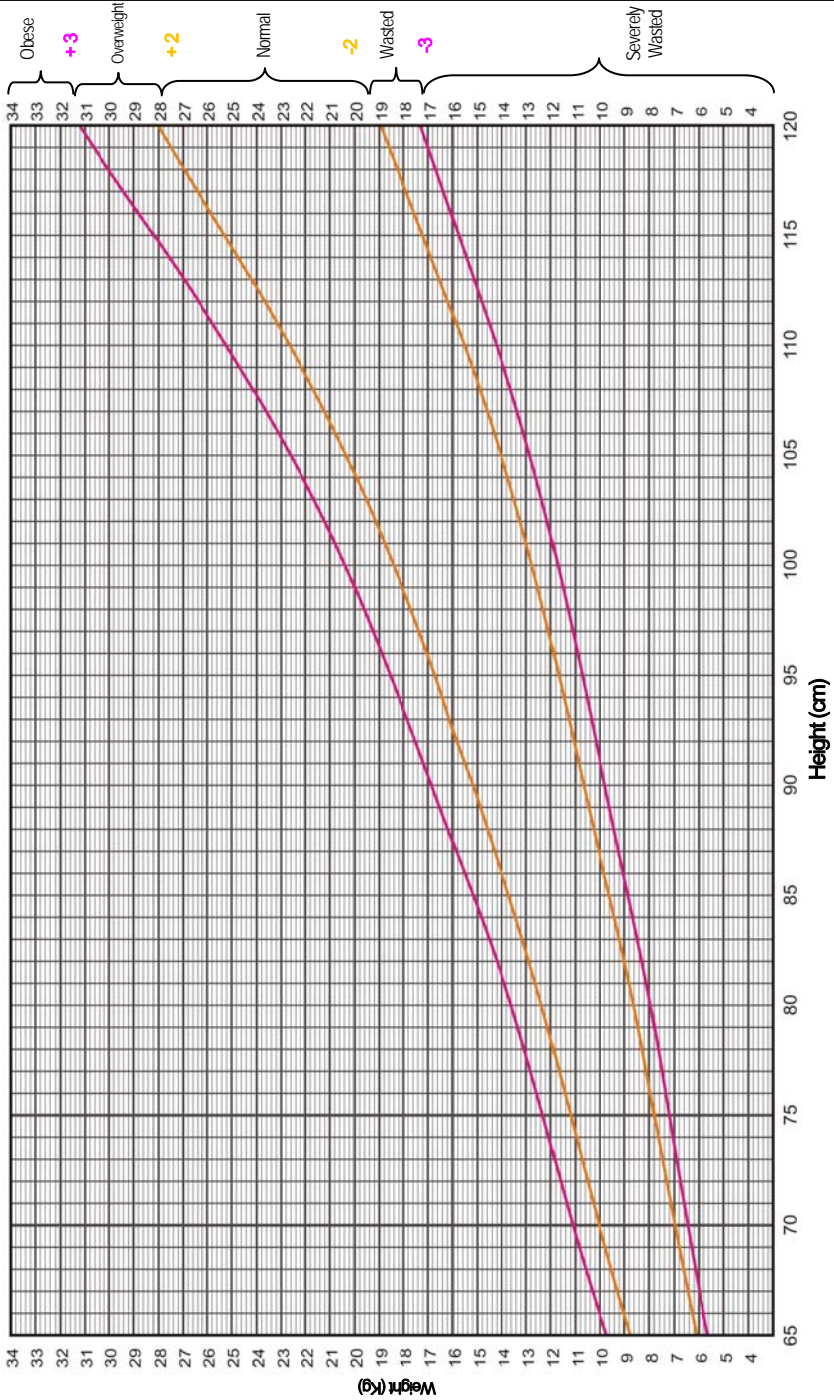


Growth Chart for GIRLS: 24 to 71 MONTHS Height-for-age





Growth Chart for GIRLS: 24 to 71 MONTHS Weight-for-height





My Baby Teeth

My baby teeth are important because:

- These act as a guide for the growth of my permanent teeth.
- These help me to eat well.
- They stimulate my jaw to grow.
- They play a major role in my proper speech development especially the **FRONT TEETH**

My Oral Health Condition

A. Check (/) if present (x) if absent

Date of Oral Examination					
Dental Caries					
Gingivitis/Periodontal Disease					
Debris					
Calculus					
Abnormal Growth					
Cleft Lip/Palate					
Others (supernumerary/mesiodens, etc)					

B. Indicate Number

No. of Perm. Teeth Present					
No. of Perm. Sound Teeth					
No. of Decayed Teeth (D)					
No. of Missing Teeth (M)					
No. Filled Teeth (F)					
Total DMF Teeth					
No. of Temp. Teeth Present					
No. of Temp. Sound Teeth					
No. of decayed Teeth (d)					
No. of filled Teeth (f)					
Total no. of Teeth					



During the First 6 Years:

- Clean my gums and tongue with clean cloth, gauze or cotton soaked in cooled boiled water at least once a day
- Teething starts at 5-6 months. Give me biscuits to relieve the pain and discomfort caused by teething.
- As soon as my first tooth erupts, start brushing it using a soft bristled toothbrush and toothpaste with fluoride and bring me to the dentist for my first dental visit.
- As I grow, teach me to brush my teeth properly after every meal.
- Encourage me to eat vegetables and drink fruit juices and milk.
- Don't let me use teethers or pacifiers for these can cause mal-alignment of my teeth and deform my jaw.
- Give me sweets occasionally but always make sure that I brush my teeth after eating to prevent dental caries.
- Discourage thumb sucking, lip biting, teeth grinding, nail biting and tongue thrusting as this develop into undesirable habits and improper growth of my teeth.

6 Years Onwards:

- My teeth starts to loosen and fall out giving way to the eruption of the permanent teeth starting 6 years old.
- Let me continue proper brushing of teeth every after meal.
- Let me continue eating nutritious foods .
- Bring me to the dentist 2 times a year for check up and treatment. If available, the dentist will put sealant on my teeth when I am about 5-6 years old.
- At age 12, all my teeth are replaced with permanent teeth.
- My set of permanent teeth is completed when I reach 17-22 years of age.



A. Oral Health Condition

Year I—Date _____

				55	54	53	52	51	61	62	63	64	65				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28		
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				85	84	83	82	81	71	72	73	74	75				

Year II—Date _____

				55	54	53	52	51	61	62	63	64	65				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				85	84	83	82	81	71	72	73	74	75				

Year III—Date _____

				55	54	53	52	51	61	62	63	64	65				
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18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28		
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				85	84	83	82	81	71	72	73	74	75				



Year IV—Date _____

																		55	54	53	52	51	61	62	63	64	65																		
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28																														
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38																														
																		85	84	83	82	81	71	72	73	74	75																		

Year V—Date _____

																		55	54	53	52	51	61	62	63	64	65																		
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28																														
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38																														
																		85	84	83	82	81	71	72	73	74	75																		

Capital letters shall be used for recording the condition of permanent dentition and small letters for the status of temporary dentition.

	Permanent	Tooth Condition	Temporary
Legend:	✓	Sound	✓
	D	Decayed	d
	F	Filled	f
	M	Missing	m
	Un	Unerupted	un
	JC	Jacket Crown	jc
	P	Pontic	p
 Legend:	 S	 Sealant	
	PF	Permanent Filling (composite, AM/ART)	
	TF	Temporary Filling	
	X	Extraction	
	O	Others	



Summary of Services Rendered										
Date	Tooth No.	Oral Propyhy	Temp. Filling	Perm. Filling	Seal-ant	Exo	Consul-tation	Others(Specify)	Remarks	Signature



Proper Tooth Brushing



It is important to teach your child proper tooth brushing techniques to prevent tooth decay. You may teach the following techniques:

1. Brush outer part of the upper teeth from the gums downward.



2. Brush inner part of the upper teeth from the gums downward.



3. Using the short back-and-forth stroking "scrubbing" motion brush the upper chewing surfaces of the teeth.



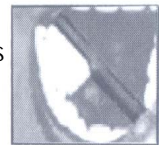
4. Brush the tongue.



5. Brush outer part of the lower teeth from the gums upward.



6. Brush inner part of the lower teeth from the gums upward.



7. Brush the lower chewing surface of the teeth.



8. After brushing, use dental floss to clean in-between the teeth.





As Early Childhood Screening Tool

(Adopted from Coordinator's Notebook, an International Resource for ECD)



- You and your husband or other caregivers who are part of the child's daily life can do this level of screening.
- Your child may have a problem in these areas when he or she presents any of the following behaviors.
- If your child is identified to have problems, you should immediately see a health worker:

The following is a simple screening tool which you, your husband or any caregiver can use. Place a check (✓) mark in the appropriate box if you observe the child has this difficulty. Remember to immediately consult a health worker if a problem has been identified.

HEARING—If your child:

- Does not turn towards the source of new sounds or voices
- Has frequent ear infections (discharge from ear, earache)
- Does not respond when you call unless he can see you
- Watches your lips when you speak
- Talks in a very loud or soft voice
- Does not talk or talks strangely

SEEING—If your child:

- Often is unable to find small objects which he or she dropped
- Has red eyes or chronic discharge from eyes, a cloudy appearance to eyes, or frequently rub eyes and says they hurt
- Often bumps into things while moving around



- Holds head in an awkward position when trying to look at something
- Sometimes or always crosses one or both eyes (after 6 months of age)

TALKING—If your child:

- Does not say *mama/mommy/nanay* by 18 months of age
- Cannot name a few familiar objects or people by age 2
- Cannot repeat simple songs or rhymes by age 3
- Is not talking in short sentences by age 4
- Is not understood by people outside the family by age 5
- Is talking differently from other children of the same age

UNDERSTANDING—If your child:

- Does not react to own name by age 1
- Cannot identify parts of face by age 3
- Cannot answer simple questions by age 4
- Cannot follow simple stories by age 5
- Seems to have difficulty in understanding things you are saying, when compared to other children at the same age

PLAYING—If your child:

- Does not enjoy playing waving games by age 1
- Does not play with common objects (e.g. spoon and pot) by age 3
- Does not join games with other children by age 4 (e.g. catch, hide and seek)
- Does not play like other children of the same age

MOVING—If your child:

- Is unable to sit unsupported by 10 months
- Cannot walk without help by age 2
- Cannot balance on one (1) foot for a short time by age 4
- Moves very differently from other children of the same age



Developmental Milestones



At 4 Months of Age

I am able to appreciate bright colors, follow moving objects with my eyes, smile, and recognize your voice and your face. I am fond of gurgling and making vocal sounds, lifting my head and laughing. My smiles are special for Mommy and Daddy.

Show me bright colored objects, talk to me, give me more space to play to stretch my arms and legs.

At 8 Months

I can turn over, hold my head erect and sit upright. I can reach for objects and put these in my mouth. I am starting to learn about the people and things in the space around me. I can differentiate between family members and strangers.



Let other members of the family hold and carry me. This is the best time for me to learn to talk to another person.

Let me reach for and touch clean, safe and colorful objects. Give me safe colorful toys in different sizes and shapes that I can play with.



At 12 Months:

I recognize and search out people. I can sit alone and stand up without help. I can say meaningful words. Talk to me and teach me the name of things around me. Speaking to me will encourage language acquisition.

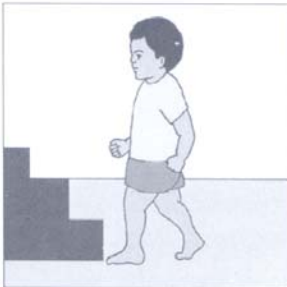
Give me the chance to walk and run actively around but under your watchful eyes. Please be more patient and understand that this is my way of learning.

At 24 Months:

I may stumble at first but wait till I am 20 months old when I can run and steadily climb up the stairs. I can enjoy stories and experimenting with things.



Read to me stories. Spend some time talking to me. I can now understand what you are saying and I can follow simple directions.



At 2-4 Years old:

I can walk up and down the stairs, pedal three-wheeled bicycles, gain control of hands and fingers. This is the right time I want to do everything by myself. I will prefer encouragement even if I don't do well. Don't be too negative about my likes and



dislikes, insistence or egoistic demands, but listen to me first. I will appreciate it if you will explain to me your reasons for your decisions. This is the best opportunity for me to learn sharing, cooperation and helping.

Enroll me in the day care nearby where I can socialize with friends.



Around 5-6 Years old:

I can draw pictures using my own imagination and can distinguish colors. I can button my shirt and tie my own shoe laces. Let me dress myself even if it takes time. I will begin to pronounce words more clearly and smoothly by listening and talking to me with slow and correct pronunciations. I will probably have close friends and acquire social skills. Help me to play with friends on good terms, and keeping promises and rules. It will be good for me to have a housework. I will assert my independence and therefore I will need help in learning how to control my own behavior.

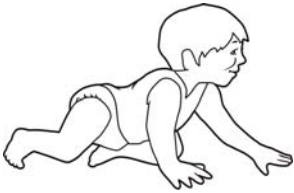
Give me more opportunities for play and exploration and help with some tasks. These are skills that I should learn to help me get ready for formal schooling.

Encourage me to be independent but set limitations to prevent untoward incidents. Doing this early in life will make me healthy and disciplined.





Practical Tips to Ensure My Safety



I am a growing child. I need proper care and guidance to achieve optimum health. Nevertheless, sometimes accidents may happen no matter how careful you are. These may often lead to trauma, both physically and emotionally, or death. Prevention plays a very important role in promoting my safety. It is certainly much cheaper and relatively easier to undertake. Follow these simple guidelines to minimize the occurrence of accidents:

- Never leave me alone without an adult supervising me.
- Let me sleep on my crib.
- Let me sleep on my back or on my side.
- Never leave me to bath alone until I am 6 years old.
- Never toss me around.
- Keep me out of direct sunlight to avoid skin burn.
- Keep matches, lighted candles, and hot liquids away from me.
- Keep kerosene, medicines, caustics and insecticides away from me.
- Never smoke or allow someone to smoke near me.
- Keep small and sharp objects away from me.
- Keep plastic bags away from me to avoid suffocation.
- Keep me away from electrical outlets and cords.
- Never leave water on a bucket or tub.
- Install safety locks on cabinets, drawers and wooden cribs.
- Install side guards on beds.
- Always let me use a seatbelt when in a car.
- Never allow me to play on the street.
- Never leave me alone inside a vehicle.
- Never allow me near swimming pool, ponds, or rivers without adult supervision.



I am a Healthy Growing Child

- I was exclusively breastfed up to 6 months and continued to be breastfed up to 2 years of age.
- I started eating complementary foods at the age of 6 months.
- I am fully immunized.
- I received Vitamin A supplementation regularly every 6 months.
- I received my first deworming at age 12 months and have my deworming every 6 months.
- I eat nutritious food.
- I have a good set of teeth because of my regular visits to the dentist
- I have weight which is within normal range.
- I have no delays in my growth and development.
- I do not have any form of disability (specify if with disability).
- I can express myself freely.
- I play and interact with other children.
- I attend a day care school/pre-school.

***I am now ready for school.
Please enroll me in Grade 1.***



My Rights as a Child



- To be born, to have a name and nationality
- To have a family who will love and care for me
- To live in a peaceful community and a wholesome environment
- To have adequate food and a healthy and active body
- To obtain a good education and develop my potential
- To be given opportunities for play and leisure
- To be protected against abuse, exploitation, neglect, violence and danger
- To be defended and given assistance by the government
- To be able to express my own views



Promote the Convention on the Rights of the Child

Build Child-Friendly Communities!





A Child's 10 Commandments to Parents

1. My hands are small. Please don't expect perfection whenever I make bed, draw a picture or throw ball. My legs are short. Please slow down so that I can keep up with you.
2. My eyes have not seen the world as yours have. Please let me explore safely, don't restrict me unnecessarily.
3. Housework will always be there. I'm little for such a short time—please take time to willingly explain things to me about this wonderful world.
4. My feelings are tender; please be attentive to my needs. Don't nag me all day long (You wouldn't want to be nagged for your inquisitiveness). Treat me as the way you want to be treated.
5. I am a special gift from God. Please take care of me as God intended you to do—holding me accountable for my actions, giving me guidelines to live by and explaining to me in a loving manner.
6. I need encouragement and praise, but not your criticism to grow. Please go easy on the criticism; remember, you can criticize the things that I do without criticizing me
7. Please give me freedom to make decisions concerning myself. Permit me to fail so that I can learn from my mistakes. Then someday I'll be prepared to make the kind of decisions life requires me.
8. Please don't do things over for me. Somehow that makes me feel that my efforts didn't quite measure up to your expectations. I know it's hard, but please don't try to compare me with my brother or my sister.
9. Please don't be afraid to leave for a weekend. Kids need vacations from parents, just as parents need vacation from their kids.
10. Please take me to church regularly, setting a good example for me to follow. I enjoy learning about God.



Schedule of Home Visit During Pregnancy & Postpartum

Type of Home Visit	Date of Visit	Services Done	Date of Next Visit	Name of Health Provider
Pregnancy Visit				
1st Visit				
	AOG:			
2nd Visit				
	AOG:			
3rd Visit				
	AOG:			
4th Visit				
	AOG:			
Postnatal Visit				
1st Visit				
2nd Visit				
3rd Visit				
4th Visit				
Extra Visits for Small Babies				
Extra Visit (1)				
Extra Visit (2)				

* AOG: Age of Gestation



Other Home Visits Conducted			
Date of Visit	Services Given	Date of Next Visit	Name of Health Provider