NEW MEXICO
Early Childhood
Education & Care Department

Maternal-Child Health Information Form - Child

Client ID	Child Name	Caregiver Name

Birth of Baby Information	
Date of Birth	
What did baby weigh at birth?	_____ ***Lbs.***_____***Ounces***
At how many weeks was baby born?	
Newborn Hearing Screening ☐ Pass ☐ Fail ☐ Follow up Notes from Follow up	

Breastfeeding (Yes, No, N/A)	***Initial***	***Qtr. 2***	***Qtr. 3***	***Qtr.4***
Did you begin breastfeeding your baby?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
If yes, does your baby receive any amount of breast milk by any means (cups, bottle, etc.)?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Are you still breastfeeding your baby?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
When did you stop breastfeeding?	***Date:***			

Child Health Information	***Initial***	***Qtr. 2***	***Qtr. 3***	***Qtr.4***
Child Health insurance (check all that apply)	☐ No insurance coverage ☐ Private insurance/other ☐ Medicaid ☐ New Mexico's Kids (S-CHIP) ☐ Use Indian Health Services ☐ Tricare (military) ☐ If Other, specify: _____	☐ No change ☐ Change	☐ No change ☐ Change	☐ No change ☐ Change
What is your child's usual source of medical care?	☐ Doctor's/Nurse Practitioner's Office ☐ Hospital or emergency room ☐ Hospital Outpatient ☐ Federally Qualified Health Center ☐ Retail Store or Minute Clinic ☐ If Other, specify: _____ ☐ None	☐ No change ☐ Change	☐ No change ☐ Change	☐ No change ☐ Change

Child Health Information continued	***Initial***	***Qtr. 2***	***Qtr. 3***	***Qtr.4***
How many times has your child been in the hospital emergency room in the past 3 months? ***Please select the # of times:***	☐ None ☐ x1 ☐ x2 ☐ x3 or more Date(s) _____	☐ None ☐ x1 ☐ x2 ☐ x3 or more Date(s) _____	☐ None ☐ x1 ☐ x2 ☐ x3 or more Date(s) _____	☐ None ☐ x1 ☐ x2 ☐ x3 or more Date(s) _____
Please check the applicable reason, if child has been in the emergency room: ☐ Injury from accident ☐ Reported child abuse or neglect ☐ Use ER for emergency medical care ☐ Use ER for regular medical care	☐ Accident ☐ Child abuse/ neglect ☐ ER – emergency ☐ ER – regular	☐ Accident ☐ Child abuse/ neglect ☐ ER – emergency ☐ ER – regular	☐ Accident ☐ Child abuse/ neglect ☐ ER – emergency ☐ ER – regular	☐ Accident ☐ Child abuse/ neglect ☐ ER – emergency ☐ ER – regular
Does your child have a usual source of dental care?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Well Child Visit & Immunization Schedule	*Initial*	*Qtr. 2*	*Qtr. 3*	*Qtr. 4*
Has your child had all recommended immunizations?	☐ Yes ☐ No	☐ No change ☐ Change	☐ No change ☐ Change	☐ No change ☐ Change
Has your child had the COVID-19 vaccine?	☐ Yes ☐ No	☐ No change ☐ Change	☐ No change ☐ Change	☐ No change ☐ Change
Did you take your baby for a medical check-up, or do you have an appointment scheduled?	☐ Yes ☐ No	☐ No change ☐ Change	☐ No change ☐ Change	☐ No change ☐ Change

Age/Well Child Visit *Please indicate (Yes, No). If yes, please provide the date*	**Vaccines**
Birth/2-3 days The first visit to Dr. office after the child is born, typically 3-5 days ☐ Yes Date _____ ☐ No	**Hep. B #1 ☐**
2 weeks-1 Month Growth and development, newborn screen ☐ Yes Date _____ ☐ No	**Hep. B #2 ☐**
2 Months Growth and development, immunizations ☐ Yes Date _____ ☐ No	**DTAP #1 ☐ IPV #1 ☐ HIB #1 ☐ PCV #1 ☐ Rotavirus #1 ☐**
4 Months Growth and development, immunizations ☐ Yes Date _____ ☐ No	**DTAP #2 ☐ IPV #2 ☐ HIB #2 ☐ PCV #2 ☐ Rotavirus #2 ☐**
6 Months Growth and development, immunizations ☐ Yes Date _____ ☐ No	**DTAP #3 ☐ IPV #3 ☐ HIB #3 ☐ PCV #3 ☐ Rotavirus #3 ☐**
9 Months Growth and development, or missed immunizations ☐ Yes Date _____ ☐ No	**Hep. B #3 ☐**
12 Months Growth the development, immunizations, lead, and hemoglobin screening ☐ Yes Date _____ ☐ No	**Varicella #1 ☐ MMR #1 ☐ PCV #4☐**
15 Months Growth and development, immunizations ☐ Yes Date _____ ☐ No	**DTAP #4 ☐ HIB #4☐**
18 Months Growth and development, immunizations, hemoglobin screening ☐ Yes Date _____ ☐ No	**Hep. A #1 ☐**
2 years* *Well-child visits are yearly starting at 2 years of age. Growth and development, lead screening ☐ Yes Date _____ ☐ No	**Hep. A #2 ☐**
3 Years Growth and development, vision screening ☐ Yes Date _____ ☐ No	**Vaccine Catch up**
4 Years Growth and development, vision and hearing screening, immunization ☐ Yes Date _____ ☐ No	**DTAP #5 ☐ IPV #4 ☐ MMR #2 ☐ Varicella #2 ☐**

5 Year Yearly well visits with immunizations ☐ Yes Date _____ ☐ No	
Vision Screening Completed? ☐ Yes ☐ No	**If no, please explain**
Vision Follow-up needed? ☐ Yes ☐ No ☐ Referred to NMSBVI ☐ Referred to optometrist or pediatric ophthalmologist	**If no, please explain**
Hearing Screening completed? ☐ Yes ☐ No ☐ OAE: ☐ Pass ☐ Refer ☐ TYMP: ☐ Pass ☐ Refer	**If no, please explain**
Was a hearing referral offered? ☐ Yes ☐ No	**Referred to:**

Safe Sleep Practices

(Only ask this for children under 12 months)

Please indicate (Yes, No, N/A) and Date for each Qtr.	***Initial***	***Qtr. 2***	***Qtr. 3***	***Qtr. 4***
Do you always follow safe sleep practices?				
Do you place your child to sleep on his/her back?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
When you place your child to sleep, do you avoid soft bedding such as soft mattresses, blankets, and pillows?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Do you always place your child to sleep alone in his/her own bed (including without his/her siblings)?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Early Literacy	***Initial***	***Qtr. 2***	***Qtr. 3***	***Qtr. 4***
How many times per week do you or a family member read, tell stories, or sing songs to your child?				
1. Daily	☐ Daily	☐ Daily	☐ Daily	☐ Daily
2. 3-5 times per week	☐ 3-5	☐ 3-5	☐ 3-5	☐ 3-5
3. 1-3 times per week	☐ 1-3	☐ 1-3	☐ 1-3	☐ 1-3
4. Do not read, tell stories, or sing songs	☐ Do not…	☐ Do not…	☐ Do not…	☐ Do not…