

## **HEALTH BOOKLET**

Please take care of this booklet and bring it along whenever your child visits a doctor, nurse or other healthcare professionals.

As a signatory to the United Nations Convention on the Rights of the Child, the Ministry of Health Singapore "strives to ensure that no child is deprived of his or her right of access to a high standard of health care services".

### Dear Parents/Guardians

All parents want the best for their child/ward. Laying a strong foundation for your child's health is the best gift and head start you can provide for in his/her life. This will set your child on the path of optimal growth and good health, allowing him/her to develop to his/her fullest potential and prevent the onset of health problems.

This Health Booklet contains information to help you monitor the growth and development of your child from birth to school age. It is important that you bring this book along when your child visits the doctor/hospital, and ensure that health information such as immunisation records, allergies and any other medical conditions are updated promptly by the attending professional. This will fulfil a key objective of this booklet – a personalised data bank of health and medical records of the child, allowing for medical history to be retrieved instantly should there be a need.

The School Health Service team visits schools annually to conduct health examinations and to administer the necessary immunisations for students. Your child should submit the Health Booklet, immunisation certificates and other medical documents to the nurses prior to the screening to facilitate medical background checks, and the recording of the child's growth and development after screening. Any information which you provide, results and follow-up activities from the health screening will be kept confidential and will only be shared with other healthcare providers and the relevant school authorities. For this purpose, the information may be placed on a database of health information known as the Electronic Medical Records Exchange (EMRX) System. The health information may also be collated and used for national public health policy planning, ethically approved research, official reports and publications. Full confidentiality is ensured, i.e. your child's identity will not be revealed.

We would like to highlight some key sections of this Health Booklet which you are encouraged to read and/or complete prior to your clinic visits:

- **Developmental Checklists**: Please complete these checklists as it will highlight any potential developmental delays your child may have. The number at the right of each developmental milestone is the age when 90% of Singapore children have achieved that particular skill. If your child is not able to achieve a certain milestone, please discuss this with your doctor.
- **Information on Allergies**: It is vital that the attending doctor completes this table if your child has any allergy, as extra precautions would need to be taken to prevent any complication.
- Child Safety Checklist: This checklist will help you to create a child-friendly and safe environment for your child.

We hope you will find the information in this Health Booklet useful and seek your active participation and partnership in monitoring the health of your child with this booklet. Let's work together to ensure your child gets the best head start possible for his/her future!

# INFORMATION ON ALLERGIES (To be completed by doctor)

	Signature					
	Name of Doctor					
	Date					
Please tick as appropriate	Suspected Allergy					
Please tick as	Confirmed Allergy					
	Type of allergic reaction (e.g. anaphylaxis, urticaria) Allergy					
	ltem(s) that the child is allergic to					
	o Z					

### **CONTENTS**

SECTION 1	
BIRTH RECORD AND PARTICULARS OF CHILD AND PARENTS	3
HEALTH AND DEVELOPMENT RECORDS (0-6 years)	
Child Developmental Screening	5
Screening at 4-8 weeks  Developmental Screening Checklist at 4-8 weeks  Physical examination at 4-8 weeks	7
Screening at 3-5 months  Developmental Screening Checklist at 3-5 months  Physical examination at 3-5 months	9
Screening at 6-12 months  Developmental Screening Checklist at 6-12 months  Physical examination at 6-12 months	12
Screening at 15-18 months  Developmental Screening Checklist at 15-18 months  Physical examination at 15-18 months	15
Screening at 2-3 years  • Developmental Screening Checklist at 2-3 years  • Physical examination at 2-3 years	18
Screening at 4-6 years  • Developmental Screening Checklist at 4-6 years  • Physical examination at 4-6 years	22
GROWTH CHARTS	26
ORAL HEALTH INFORMATION	50

SECTION 2	
CHILD SAFETY CHECKLIST	52
SECTION 3	
NATIONAL CHILDHOOD IMMUNISATION SCHEDULE, SINGAPORE	55
IMMUNISATION RECORD OF NATIONAL CHILDHOOD VACCINATIONS	57
IMMUNISATION RECORD OF OPTIONAL VACCINATIONS	59
SECTION 4	
SUMMARY OF CLINIC/HOSPITAL MEDICAL RECORDS	60
APPOINTMENT DATES	64
SECTION 5	

SCHOOL DENTAL AND SCHOOL HEALTH SCREENING RECORDS (COMPUTER PRINTOUTS) AND OTHER MEDICAL RECORDS

### **BIRTH RECORD AND PARTICULARS OF CHILD**

Name of child (in BLOCK LETTERS)

Birth Certificate No.:			
Date of Birth:		Time of Birth:	hrs
Address:			
Place of Delivery:			
Sex: Male	Female Et	hnic Group:	
Duration of Gestation:	Weeks		
Mode of Delivery:	Normal LSCS	Vacuum extraction Forceps	Other
Apgar Score:	1 min 5 min		
Weight at Birth:	gm		
Length at Birth:	. cm		
Head Circumference:	. cm		
PARTICULARS O	E DADENTS		
PARTICOLARS OF	PARENTS		
MOTHER			
Name:		NRIC/Passport No.:	
Occupation:			
Tel (RES):	Tel (OFF):	Tel (HP):	
FATHER			
Name:		NRIC/Passport No.:	
Occupation:			
Tel (RES):	Tel (OFF):	Tel (HP):	

SIGNIFICANT EVENTS DU	JRING PREGNAN	CY / DELIVERY	
Jaundice No Yes	Phototherapy	Yes	Exchange Transfusion Yes
NEWBORN SCREENING			
G6PD Deficiency	Yes		
TSH: mIU/L	fT4:	pmol/L	Date:
*IEM Screening Done No	Yes		Date:
Hearing Screening			
** OAE Date:		*** ABAER	Date:
Left Pass:	Yes .	Left Pass:	No Yes
Right Pass:	Yes	Right Pass:	No Yes
Needs further evaluation:	No Yes		
Remarks (if any):			
INVESTIGATION(S) DONE	E (if any)		
Serum Bilirubin (highest level) :		μmol/L	Date:
Blood Group:			Date:
Other Tests: (please specify)			Data
			Date:
			Date:
INFORMATION ON DISCH	ARGE FROM HO	SPITAL	
Date:	Weight:	gm Bre	east Feeding: Yes No
Serum Bilirubin (if done) before disc	charge:	μmol	/L

Instructions to doctors and nurses:

All weight, length and head circumference measurements are to be entered on the charts on pages 26-41

Please document additional medical findings in the summary of clinic/hospital medical record section on pages 59-63

\*IEM =Inborn Errors of Metabolism, \*\* OAE= Oto-Acoustic Emission, and \*\*\*ABAER= Automated Brainstem Auditory Evoked Response.

### **CHILD DEVELOPMENTAL SCREENING**

AGE	TYPE OF SCREENING	IMMUNISATION	
1 month	<ol> <li>Growth monitoring: weight, length, OFC*</li> <li>Feeding history</li> <li>Hearing screening if not done at birth</li> <li>Physical examination and developmental check on page 7-8</li> </ol>	BCG, Hep B-1 at birth Hep B-2 1 month after Hep B-1	
3 months	3 months  1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Hearing screening if not done at birth/4-8 weeks		
	4. Parents/Caregivers please answer the questions below***:		
	<ul> <li>Can your child keep his/her head upright when held in a sitting position?</li> <li>Can your child respond to the parent's/ Yes/No caregiver's voice by quietening down if crying or smiling?</li> <li>Can your child visually follow Yes/No the parent's/caregiver's movements,</li> </ul>		
	including turning his/her head from side to side?		
	5. Physical examination and developmental check on page 9-11		
4 months	Growth monitoring : weight, length, OFC*     Feeding history	DTaP-2, Polio-2, Hib-2	
5 months	Growth monitoring : weight, length, OFC*     Feeding history	DTaP-3, Polio-3, Hib-3, PCV-2	
6 months	<ol> <li>Growth monitoring: weight, length, OFC*</li> <li>Feeding history</li> <li>Parents/Caregivers please answer the questions below***:</li> </ol>	Нер В-3	
	<ul> <li>Can your child roll over?</li> <li>Can your child turn towards a sound?</li> <li>Can your child reach out for things?</li> </ul> Yes/No		
	Hearing screening     Physical examination and developmental check     on page 12-14		
9 months	<ol> <li>Growth monitoring: weight, length, OFC*</li> <li>Feeding history</li> <li>Hearing screening</li> <li>Test for squint</li> <li>Physical examination and developmental check on page 12-14 (if not done at 6 months)</li> </ol>		

Legend:

\* OFC - Occipito-Frontal Circumference
All height, weight and OFC measurements must be charted into the appropriate growth charts

\*\*\* If the answer to any of these questions is 'No', please refer to your doctor.

### CHILD DEVELOPMENTAL SCREENING

AGE	TYPE OF SCREENING	IMMUNISATION
12 months		PCV Booster MMR-1
15 months	<ol> <li>Growth monitoring : weight, height, OFC</li> <li>Parents/Caregivers please answer the questions below***:</li> </ol>	MMR-2*
	<ul> <li>Can your child walk a few steps?</li> <li>Can your child wave bye-bye or clap hands?</li> <li>Can your child say Papa or Mama?</li> </ul> Yes/No	
	3. Physical examination and developmental check on page 15-17	
18 months	Growth monitoring : weight, height, OFC     Physical examination and developmental check on page 15-17 (if not done at 15 months)	DTaP Booster, Polio Booster, Hib Booster
3 years	<ol> <li>Growth monitoring: weight, height, OFC, BMI</li> <li>Test for squint</li> <li>Parents/Caregivers please answer the questions below***:</li> </ol>	
	Can your child climb stairs without     Yes/No     assistance?	
	Can your child speak spontaneously in Yes/No sentences with 4 syllables?	
	<ol> <li>Physical examination and developmental check on page 18-21.</li> </ol>	
4 - 5 years	<ol> <li>Growth monitoring: weight, height, BMI</li> <li>Visual acuity and test for squint</li> <li>Stereopsis</li> <li>Physical examination and developmental check on page 22-25</li> </ol>	

Legend: \* MMR-2 can be given at 18 months with DTaP Booster, Polio Booster and Hib Booster for the convenience of parents.

<sup>\*\*\*</sup> If your answer to any of these questions is 'No', please refer to your doctor.

### **SCREENING AT 4 WEEKS TO 8 WEEKS**

Date of Screening:	Age:	Main caregiv	/er:	
DEVELOPMENTAL CHE (TO BE COMPLETED BY Please tick "Yes"/"No"		YES	NO	Age (mths) when 90% achieve the milestone
Personal Social				
1 When you face your ba at you and watches you	by lying on his back, he looks u. (Regards face)			1
When you talk and smi at you without you tick (Smiles spontaneously)				1
Fine Motor-Adaptive				
-	nis back, he can follow the s, from one side to facing ows to mid-line)			1.5
4 When your child is on h movement of an object line to the other side. (I	, from one side, past the mid-			2.5
Language				
see, i.e. outside his line	a bell sound that he cannot of vision, he responds with eye a breathing pattern or changes to a bell)			1
	ds other than crying, such as r short vowels sounds like "UH", alises)			1.5
Gross Motor				
7 While your child is lying and legs equally. (Equa	g on his back, he moves his arm I movement)	S		1
	ed on his stomach, he lifts his he surface. (Lifts head)			1
lift his head so that the	ed on his stomach, he can angle between his face and on is approximately 45 degrees.			3
Comments of Doctor/Nur	se on Developmental Checklist	completed l	by parents:	

### **SCREENING AT 4 WEEKS TO 8 WEEKS**

GROWTH			
Weight:	kg	% Occipito-Frontal Circumference: cm	%
Length:	cm	%	
HEARING	SCREENING (if	not done at birth)	
Oto-aco	ustic emission (OAE)	Automated Brainstem Auditory Evoke Response (ABAER)	∍d
Date:		Date:	
Left Pass:	No Y	'es Left Pass: No Yes	
Right Pass:	No Y	res Right Pass: No Yes	
Needs further e	valuation: N	Yes Yes	
Remarks (if any)	):		
PHYSICAL	. EXAMINATION		
		ng object: Right eye Left eye	
	Cornea/Lens	Pupillary Light reflex	
	Red Reflex	Nystagmus: Yes No	
	Eye movements		
	-		
	Facies	Heart Genitals Posture	
	Fontanelles	Lungs Arms Muscle to	ne
	Ears	Abdomen Legs Back	
	Mouth/Palate		
Reflexes:	Neck	Femoral pulses  Grasp  Tonic Neck  Walking/9	Stopping
nemexes.	Piolo	orasp Tollic Neck Walkings	stepping
OUTCOME	OF EXAMINATI	ION	
Normal		Next routine check at:	
Needs Fo	llow Up At The Clinic	Review:	
Needs Fu	rther Evaluation	Referred to:	
Remarks (if any)	):		
Dankan / No		Simulania	
Doctor / Nurse:		Signature:	
Clinic:		Date:	

### **SCREENING AT 3 MONTHS TO 5 MONTHS**

D	ate of Screening:	Age:	Main caregiv	ver:	
(1	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS ease tick "Yes"/"No"	3)	YES	NO	Age (mths) when 90% achieve the milestone
P	ersonal Social				
1	When you face your baby lying on at you and watches you. (Regards				1
2	When you talk and smile to your be at you without you tickling or touc (Smiles spontaneously)				1
3	Your child displays excitement like arms, on seeing an attractive toy. (		g		5.5
Fi	ne Motor-Adaptive				
4	When the child is on his back, he of movement of an object, from one line to the other side. (Follows pas	side past the mid-			2.5
5	Your child can touch his own hand mid-line of his body. (Hands toget				3.5
6	When you bring a rattle to touch t your child's fingers, he grasps the a few seconds. (Grasps rattle in ha	rattle in the hand fo	r		4
7	When your child is on his back, his follow the movement of an object the mid-line and right over to the 180 degrees)	from one side, past			4.5
8	Your child is able to focus on smal placed in front of him on the table		,		5.5
L	anguage				
	When your child hears a bell sound see, i.e. outside his line of vision, he movements, changes in breathing in activities. (Responds to a bell)	e responds with eye			1
10	Your child makes sounds other that small throaty sounds or short vow "OO", "EH", "AH"(Vocalises)		,		1.5
11	Your child laughs out loud without (Laughs)	being tickled.			4.5
12	Your child turns towards the side of rattle placed out of sight about 20 (Responds to sounds)*		:		7.5

### **SCREENING AT 3 MONTHS TO 5 MONTHS**

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone
Gross Motor			
13 While your child is lying on his back, he moves his arms and legs equally. (Equal movement)			1
14 When your child is placed on his stomach, he can lift his head so that the angle between his face and the surface he is lying on is approximately 45 degrees. (Head-up 45 degrees)			3
15 When your child is placed on his stomach, he lifts his head and chest up so that he is looking straight ahead. (Holds head up - 90 degrees)			5
16 When in a sitting position, your child can hold his head upright steadily without any bobbing motion. (Sits, head steady)			5
17 When you are holding your child under his arms loosely, he is able to bear some weight on his legs for a few seconds. (Bears weight on legs)			6
*The instruction from the Denver Developmental Screening	Test (Sing	japore) has	been amended.
Comments of Doctor/Nurse on Developmental Checklist co	mpleted k	by parents:	

### **SCREENING AT 3 MONTHS TO 5 MONTHS**

GROWTH	1			
Weight:	kg	% Occipito-F	rontal Circumference:	cm %
Length:	cm	%		
HEARING	SCREENING (if	not done at birth	or at 4 weeks to 8 we	eeks old)
Oto-acc	oustic emission (OAE)		Automated Brainste Response (ABAER)	m Auditory Evoked
Date:		Į	Date:	
Left Pass:	No Y	es I	_eft Pass: No	Yes
Right Pass:	No Y	es I	Right Pass: No	Yes
Needs further e	evaluation: N	o Yes		
Remarks (if any	·):			
PHYSICA	L EXAMINATION			
		ng object: Right e	ye Left eye	
	Cornea/Lens	Pupillary Light refl	ex	
	Red Reflex	Nystagmus: Ye	es No	
		 Squint: Ye	es No	
	Ro	ving Eye Movement: Y	es No	
		Eye Movements		
	Facies	Heart	Genitals	Posture
	Fontanelles	Lungs	Arms	Muscle tone
	Ears	Abdomen	Legs	Back
	Mouth/Palate	Umbilicus	Hips	Skin
	Neck	Femoral pulse	s	
Reflexes:	Moro	Grasp	Tonic Neck	Walking/Stepping
ОИТСОМ	E OF EXAMINAT	ION		
Normal		Next routine check at:		
Needs Fo	ollow Up At The Clinic	Review:		
Needs Fu	ırther Evaluation	Referred to:		
Remarks (if any	'):			
Doctor / Nurse	:		Signature:	
Clinic:			Date:	

### **SCREENING AT 6 MONTHS TO 12 MONTHS**

D	ate of Screening:	Age:	Main caregive	er:	
	PARENTAL CONCERNS Please inform your doctor if your chil Does not babble, point or use geste Has lost any language skills Does not respond readily to affection	ures by 12 month	าร		
(1	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS) ease tick "Yes"/"No"		YES	NO	Age (mths) when 90% achieve the milestone
Pe	ersonal Social				
1	Your child displays excitement like kick arms, on seeing an attractive toy. (Exci				5.5
2	Your child will try to get a toy that he e out of reach by stretching his arms or be a toy out of reach)				6.5
3	Your child seems to be shy or wary of s (Reacts to stranger)	strangers.			10
4	When you face your child, say bye-bye him, he responds by waving his arm, he without his hands or arms being touch (Waves bye-bye)	and and fingers			10.5
5	When you clap your hands, your child r clapping his hands when you ask him t hands or arms being touched. (Claps h	o, without his			11
6	Your child can indicate what he wants or whining. He may do this by pointing making speech-like sounds or putting a carried without speaking. (Indicates was	g, pulling and arms up to be			13.5
Fi	ne Motor-Adaptive				
7	When your child is on his back, his eyes follow the movement of an object from the mid-line and right over to the other (Follows 180 degrees)	one side, past			4.5
8	Your child is able to focus on small objeplaced in front of him on the table. (Re				5.5
9	Your child can pick up a toy within his out for things. (Reaches for an object)	reach or reach			6
10	Your child will look for an object that h line of vision when his attention is focu object. (Looks for a fallen object)		S		7
11	Your child can pass something small from the other hand. (Passes a cube from ha				7.5
12	Your child can pick up a raisin by bring any part of the thumb and any one fing (Finger-Thumb Grasp)				10
13	When your child is holding a block in eable to hit them together, without his being touched by you. (Bangs 2 cubes	nands or arms			10.5

### **SCREENING AT 6 MONTHS TO 12 MONTHS**

(T	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS) ease tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone
14	Your child can pick up a small object like a raisin, using only the ends of his thumbs and index finger. (Pincer grasp)			13.5
La	nguage			
15	Your child laughs out loud without being tickled. (Laughs)			4.5
16	You child turns towards the side of the sound of a rattle placed out of sight about 20cm behind each ear. (Responds to sounds)*			7.5
17	Your child makes single sounds consisting of a consonant and a vowel, like "ba", "da", "ga", "ma". (Says single syllables)			10
18	Your child imitates any sound after you e.g. sounds like coughing, clicking of the tongue or any other speech sounds. (Imitates speech sounds)			10
19	Your child uses the word "Papa" and "Mama" specifically. (Says Papa/Mama specifically)			14.5
Gı	oss Motor			
20	When in a sitting position, your child can hold his head upright steadily. (Sits, head steady)			5
21	Your child is able to roll over from stomach to back or back to stomach. (Rolls over)			5
22	When you are holding your child under his arms loosely, he is able to bear some weight on his legs for a few seconds. (Bears weight on legs)			6
23	When your child is placed on his stomach, he can lift his head and chest up using the support of outstretched arms, so that his face is looking straight ahead and the chest is well lifted away from the surface. (Holds chest up, arm support)			7
24	Without being propped by pillows, a chair or a wall, your child is able to sit alone for more than 5 seconds. He can put his hands on his legs or on a flat surface for support. (Sits, no external support)			7.5
25	Your child can stand holding on to a chair or table for more than 5 seconds. (Stands holding on)			9
26	Your child can pull himself to a standing position by himself without help. (Pulls to stand)			10
*T	he instruction from the Denver Developmental Screening	Test (Sing	gapore) has	been amended.
C	omments of Doctor/Nurse on Developmental Checklist co	mpleted k	by parents:	
_				

### **SCREENING AT 6 MONTHS TO 12 MONTHS**

GROWTH				
Weight:	kg	% Occipito-F	rontal Circumference:	cm %
Length:		%		
OTHER SCR	EENING (e.g. H	learing Screening	)	
Remarks (if any):				
DUVCICAL	XAMINATION			
PHISICAL	:XAMINATION			
Eye Examination:	Fixation on movir	ng object: Right ey	/e Left eye	
	Cornea/Lens	Pupillary Light refl	ex	
	Red Reflex	Nystagmus: Ye	es No	
		Squint: Ye	es No	
	Rov	ring Eye Movement: Ye	es No	
		Eye Movements		
Fontane	elles	Heart	Femoral pulses	Posture
Ears		Lungs	Genitals	Muscle tone
Teeth		Abdomen	Hips	Skin
OUTCOME (	OF EXAMINATION	ON		
Normal		Next routine check at:		
Needs Follo	w Up At The Clinic			
Needs Furth	er Evaluation			
Remarks (if any):				
Doctor / Nurse:			Signature:	
Clinic:			Date:	

### **SCREENING AT 15 MONTHS TO 18 MONTHS**

Di	ate of Screening:	_ Age:	r	Main careg	iver:	
	PARENTAL CONCERNS  Please inform your doctor if your chi Does not babble, point or use gest Does not speak a single word by 1. Has lost any language skills Does not respond readily to affect	tures by 12 8 months			ties:	
Pl	ease answer the following and tick "NO"	/ "YES"				
Н	ave you any worries about your child's :		NO	YES		
•	Health and growth				Specify:	
•	Diet and feeding				Specify:	
•	Sleep				Specify:	
•	Behaviour				Specify:	
D	ISION  oes your child frown, tilt his head in orde he better or close one eye while looking i he distance in bright light?					
D th	EARING oes your child respond to sounds even v e source is not within his sight, e.g. callir s name, ringing of the telephone?					
=	EVELORMENTAL CHECKLIST					A Countle ->
(1	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS) ease tick "Yes"/"No"			YES	NO	Age (mths) when 90% achieve the milestone
(T	O BE COMPLETED BY PARENTS)			YES	NO	when 90% achieve
PI Pi	TO BE COMPLETED BY PARENTS) ease tick "Yes"/"No"	ıg, pulling		YES	NO	when 90% achieve
(1 Pi Pi	ease tick "Yes"/"No"  ersonal Social  Your child can indicate what he want or whining. He may do this by pointir making speech-like sounds. (Indicate	g, pulling s wants child copi	and	YES	NO	when 90% achieve the milestone
(1 Pi Pr 1	ersonal Social  Your child can indicate what he want or whining. He may do this by pointin making speech-like sounds. (Indicate by gestures)  When you are doing housework, your	g, pulling s wants child copi ctivities) self and d	and ies what rink	YES	NO	when 90% achieve the milestone
Pr 1 2 3	ease tick "Yes"/"No"  ersonal Social  Your child can indicate what he want or whining. He may do this by pointir making speech-like sounds. (Indicate by gestures)  When you are doing housework, your you are doing. (Imitates household ac Your child can hold a regular cup him from it without spilling much. The cup	g, pulling s wants child copi ctivities) self and d	and ies what rink	YES	NO	when 90% achieve the milestone  13.5
(TPI Pri 1 2 3 - Fi	ease tick "Yes"/"No"  ersonal Social  Your child can indicate what he want or whining. He may do this by pointir making speech-like sounds. (Indicate by gestures)  When you are doing housework, your you are doing. (Imitates household act Your child can hold a regular cup him from it without spilling much. The cup a spout. (Drinks from a cup)	eg, pulling s wants  child copictivities)  self and do should n	and lies what rink ot have	YES	NO	when 90% achieve the milestone  13.5
1 2 3 Fi 4	ease tick "Yes"/"No"  ersonal Social  Your child can indicate what he want or whining. He may do this by pointing making speech-like sounds. (Indicate by gestures)  When you are doing housework, your you are doing. (Imitates household act your child can hold a regular cup him from it without spilling much. The cup a spout. (Drinks from a cup)  Ine Motor Adaptive  Your child can pick up a small object only the ends of his thumbs and inde	g, pulling s wants  child copictivities)  self and dop should not	ies what rink ot have n, using Pincer	YES	NO	when 90% achieve the milestone  13.5  16  18.5

### **SCREENING AT 15 MONTHS TO 18 MONTHS**

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone			
Language						
7 Your child uses the word "Papa" and "Mama" specifically. (Says Papa/Mama specifically)			14.5			
8 Without coaching, pointing or helping, your child can point to at least 2 parts of his body such as nose, eyes, ears, hands, hair, legs and stomach, when asked. (Points to own body – 2 parts)			19			
9 Your child can say at least three words other than "Papa/Mama", which mean the same things each time he uses them. (Says 3 words other than Papa/Mama)			21			
Gross Motor						
10 Your child can stand alone without having to hold on to something for ten seconds or more. (Stands alone)			14.5			
11 Your child can walk well with good balance, rarely falls and does not sway from side to side. (Walks well)			16			
12 Your child can walk up several steps of the staircase by himself. He may use the wall or rail for support but not hold on to a person. (Walks up steps)			21.5			
Comments of Doctor/Nurse on Developmental Checklist completed by parents:						

### **SCREENING AT 15 MONTHS TO 18 MONTHS**

GROWTH				
Weight:	kg	% Occipito-F	Frontal Circumference:	cm %
Height:	cm	%		
PHYSICAL E	XAMINATION			
Eye Examination:	Fixation on movir	g object: Right e	ye Left eye	
	Cornea/Lens	Pupillary Light refl	ex	
	Red Reflex	Nystagmus: Y	es No	
		Squint: Y	es No	
	Ro	ving eye movement: Y	es No	
Еу	ye movements			
Fontanelles	. Пн	eart	Femoral pulses	Posture
Ears		ungs [	Genitals	Muscle tone
Teeth		bdomen [	Spine	Skin
				Gait
OUTCOME (	OF EXAMINATI	ON		
Normal		Next routine check at	:	
Needs Follo	w Up At The Clinic	Review:		
Needs Furth	er Evaluation	Referred to:		
Remarks (if any):				
Doctor / Nurse:			Signature:	
Clinic:			Date:	

D	ate of Screening:	Age:	Main careg	iver:	
	PARENTAL CONCERNS  Please inform your doctor if your chil  Does not use spontaneous (non-ec Has lost any language or social skil Does not point to show things he i Does not follow when someone is Does not respond readily to affective prefers to play alone	choed/non-i   s interested pointing sor	mitated) 2-wor	rd phrases	by 24 months
Ы	ease answer the following and tick "NO"	/ "YES"			
Н	ave you any worries about your child's :	N	O YES		
•	Health and growth			Specify:	
•	Diet and feeding			Specify:	
•	Sleep			Specify:	
•	Learning			Specify:	
•	Behaviour			Specify:	
th De th	DISION Does your child frown, tilt his head in order the better or close one eye while looking in the distance in bright light?  EARING Does your child respond to sounds even we the source is not within his sight, e.g. callin to sname, ringing of the telephone?	nto hen			
(	EVELOPMENTAL CHECKLIST TO BE COMPLETED BY PARENTS) lease tick "Yes"/"No"		YES	NO	Age (mths) when 90% achieve the milestone
P	ersonal Social				
1	Your child can use a spoon to feed hir most of the food into his mouth, spilli (Uses spoon)		is		22
2	Your child can completely remove any clothing such as his shirt, shoes or particle (Removes garment)				24
3	Your child plays imaginatively, like pla and pretending to comb the doll's hai (Combs doll's hair)		doll		24.5
4	Your child can put on any of his own of underpants, socks or shoes. (Puts on				34
5	Your child uses a friend's name when speaking to a friend (Names friend)	referring or			45.5

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone
Fine Motor Adaptive			
6 Your child can put 4 blocks, 6 blocks or 8 blocks, one on top of the other, without the blocks falling. This applies to small blocks of about one inch square in siz (Builds a tower of cubes [4 blocks, 6 blocks, 8 blocks]			23 29 35.5
7 Demonstrate drawing a vertical straight line to your child and tell him to draw one like yours. Answer "yes" if he can make a fairly vertical line of less than 30 degrees inclination. He is not allowed to trace the line and the line should be more than 5 cm long but does not have to be perfectly straight. (Imitates a vertical line)			38.5
8 Draw two lines, 4 and 5 cm long, side by side on a care Ask the child to point to the longer line.  (Picks longer line)	d		46.5
Language			
9 Your child can say at least three words other than "Papa/Mama", which mean the same things each time he uses them. (Says 3 words other than Papa/Mama)			21
10 Show your child 5 black and white drawn picture card (size 6 by 8cm) of a dog, bird, fish, bus and baby. When asked to point to each picture, one at a time, making sure the pictures are being moved around after each time, he can point to 2 pictures and 4 pictures correctly. (Points to pictures [2,4])	S		25.5 28.5
11 Your child uses a combination of at least two words to make a meaningful phrase that indicates an action, like "play ball", "want drink". (Combines 2 words)			27
12 Show your child 5 black and white drawn pictures cards (size 6 by 8cm) of a dog, bird, fish, bus, and baby. When asked to name each picture, one at a time he can name 2 pictures and 4 pictures correctly. (Names pictures [2,4])	2,		30 37
13 When asked "How old are you?", "Are you a boy or a girl?", "What is your name?", your child gives the correct answer to 2 out of 3 questions. (Knows age/sex/name)			40
Gross Motor			
14 Your child is able to stoop or bend to pick up a toy from the floor and return to a standing position without sitting down or touching the floor with his hands. (Stoops to recover)			15.5
15 Your child can walk up several steps of the staircase by himself. He may use the wall or rail for support but not hold on to a person. (Walks up steps)			21.5

(T	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS) pase tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone			
16	Your child can walk down several steps of the staircase by himself. He may use the wall or rail for support but not hold on to a person. (Walks down steps)			24.5			
17	Without holding on to any support, your child can kick a small ball like a tennis ball in a forward direction. (Kicks ball forward)			26			
18	Without holding on to any support, your child can jump up with both feet off the floor at the same time. (Jumps up)			32.5			
19	Your child can balance on each foot without any support for at least 1 second. (Balances each foot - 1 sec)			37			
20	Your child can pedal a tricycle. (Pedals tricycle)			41.5			
Comments of Doctor/Nurse on Developmental Checklist completed by parents:							

GROWTH					
Weight:k	g	%	Occipito-Fronta	al Circumference:	cm %
Height:c	:m	%	BMI:	<b>%</b>	
PHYSICAL EXA	MINATION				
Eye Examination:	Squint	: Yes	No		
Objection to occlu	usion in one eye	: Yes	No		
	Nystagmus	: Yes	No		
Roving	eye movement	: Yes	No		
Cornea/Lens	Red Ref	lex	Pupillary Ligi	nt reflex	
Eye movements					
Fontanelles	н	eart		Femoral pulses	Spine
Ears	Lu	ings		Genitals	Posture
Teeth	A	odomen		Limbs	Skin
					Gait
OUTCOME OF	EXAMINATI	ON			
Normal		Next rout	ine check at:		
Needs Follow Up	At The Clinic	Review:			
Needs Further E	valuation	Referred	to:		
Remarks (if any):					
Doctor / Nurse:			Sig	nature:	
Clinic:			Dat	re:	

Da	ate of Screening:	Age:		Main careg	iver:	
	PARENTAL/TEACHER'S CONCERNS Please inform your doctor if your chile Does not follow when someone is a large is unable to sit through, follow instance Does not respond readily to affectiant is not interested in playing with other Seems to be in his own world Becomes very upset/anxious/cling school or when he is going to a new Has great difficulty controlling his to upset Finds it hard to make friends	d has AN pointing ructions a on ners y when s w place	someth and take eparatir	ing out to e turns wh ng from yo	him en playing ou, e.g. who	en dropping him off at
Ρl	ease answer the following and tick "NO"	/ "YES"				
Ha	ave you any worries about your child's :		NO	YES		
•	Health and growth				Specify:	
•	Diet and feeding				Specify:	
•	Sleep				Specify:	
•	Learning				Specify:	
•	Behaviour				Specify:	
se th HI Do th	sion Des your child frown, tilt his head in order the better or close one eye while looking in the distance in bright light?  EARING Des your child respond to sounds even w the source is not within his sight, e.g. calling to sname, ringing of the telephone?	nto				
(1	EVELOPMENTAL CHECKLIST O BE COMPLETED BY PARENTS) ease tick "Yes"/"No"			YES	NO	Age (mths) when 90% achieve the milestone
Pe	ersonal Social					
1	Your child can put on any of his own ounderpants, socks or shoes. (Puts on					34
2	Your child uses a friend's name when speaking to a friend. (Names a friend)		or			45.5
3	Your child can brush his teeth with so (Brushes teeth)	me help.				51
4	Your child can dress himself up compl correctly without help except for tying buttoning or zipping the back of dress (Dresses, with no help)	g shoe la				54
5	Your child can brush all his teeth along placing the toothpaste on the toothbrody of this without help or supervision.	rush. He	-			69

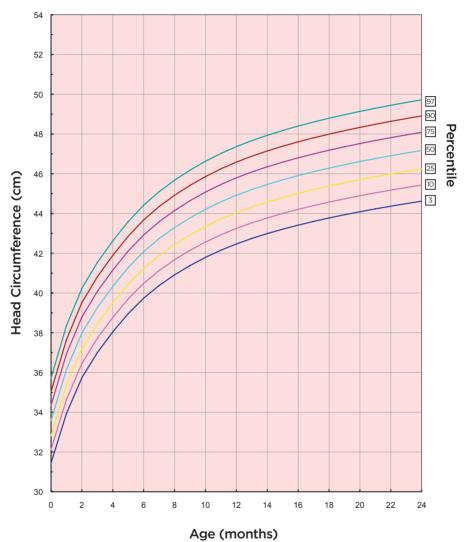
DEVELOPMENTAL CHI (TO BE COMPLETED B Please tick "Yes"/"No"		YES	NO	Age (mths) when 90% achieve the milestone
Fine Motor Adaptive				
	e card of a circle, your child can mating a circle that is closed or Copies a circle)			47
	e of a cross, your child can draw rily straight exactly, which (Copies a cross)			50
	e card of a square, your child n straight lines and with 4 square uare)			56
	a picture of a boy or a girl, your t 3 or 6 parts. (Draws person			57.5 62.5
Language				
cards (size 6 by 8 cm baby. When asked to	ck and white drawn picture of a dog, bird, fish, bus and name each picture, one at a time, as and 4 pictures correctly.			30 37
a girl?", "What is your	l are you?", "Are you a boy or name?", your child gives the ut of 3 questions. (Knows age/			40
12 Your child can count to (Rote counts to 10)	from 1 to 10 in correct sequence.			52
pencil, chair), i.e. "Wh	nctions of these 3 objects (cup, at is a cup used for?" your child nswer to all 3 questions. (Knows cup, pencil, chair])			55.5
	d blocks in red, blue, green and ne can name at least 3 colours se colours)			63.5
next to the blocks. To the paper". After he l from the paper and pl Repeat the procedure	of your child and a piece of paper all your child to "put one block on has done so, remove the block ace it back with the other blocks." requesting 3 then 5 blocks. locks (3,1,5). (Places and counts)			64
Gross Motor				
16 Your child can pedal a	a tricycle. (Pedals tricycle)			41.5
17 Your child can hop at foot without any supp	least 2 times in a row, on one port. (Hops)			53.5

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No"	YES	NO	Age (mths) when 90% achieve the milestone
18 Your child can balance on one foot (either foot) unsupported for at least 5 seconds. (Balances each foot - 5 seconds)			57
Comments of Doctor/Nurse on Developmental Checklist	completed l	by parents:	

GROWTH			
Weight:	kg %	BMI: %	
Height:	cm %		
PHYSICAL EXA	AMINIATION		
PHYSICAL EX	AMINATION		
Eye Examination:	Squint: Yes	No	
	Nystagmus: Yes	No	
Rovin	g eye movement: Yes	No	
Cornea/Lens	Red Reflex	Pupillary Light reflex	
Vision Test:	Right eye:	Left eye:	
	Stereopsis:	Pass Refer for further	evaluation
Eye Movements and o	other visual findings:		
Ears	Heart	Femoral pulses	Spine
Teeth	Lungs	Genitals	Posture
Skin	Abdomen	Limbs	Gait
OUTCOME OF	EXAMINATION		
Normal	Next ro	utine check at:	
Needs Follow U	Jp At The Clinic Review	:	
Needs Further	<b>Evaluation</b> Referre	ed to:	
Remarks (if any):			
Doctor / Nurse:		Signature:	
Clinic:		Date:	

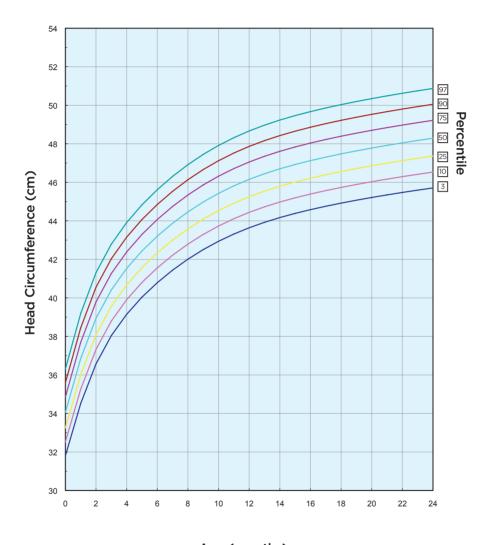


# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE GIRLS AGED 0 TO 24 MONTHS





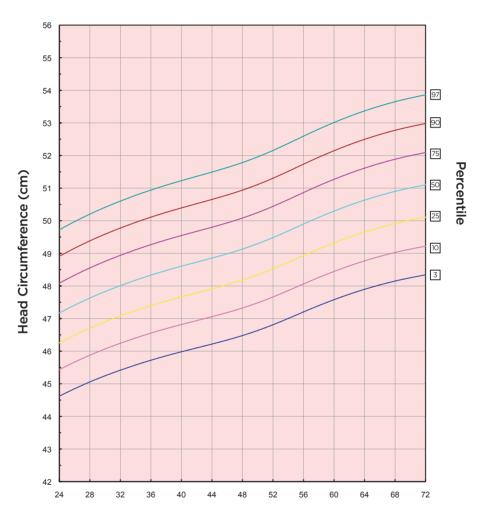
# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE BOYS AGED 0 TO 24 MONTHS



Age (months)



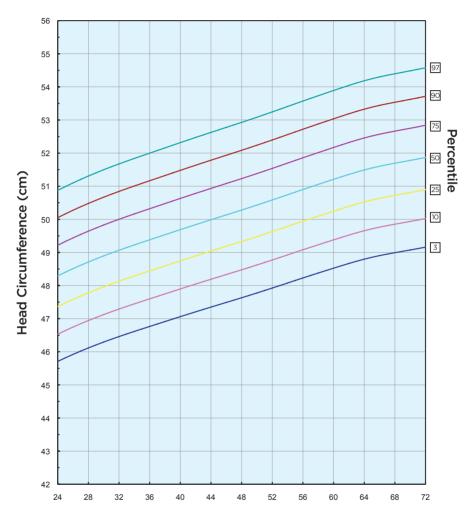
# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



Age (months)



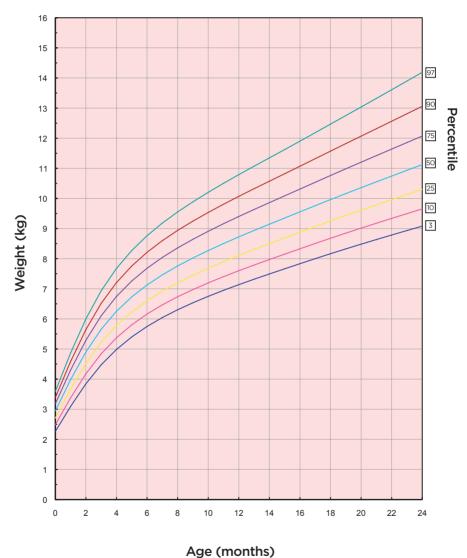
# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE BOYS AGED 24 TO 72 MONTHS



Age (months)

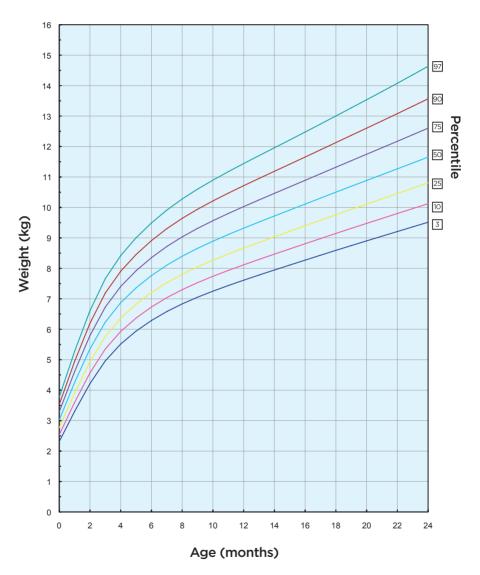


### PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 0 TO 24 MONTHS



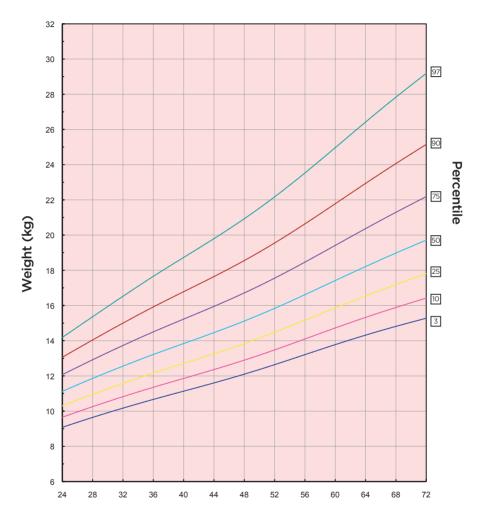


### PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS





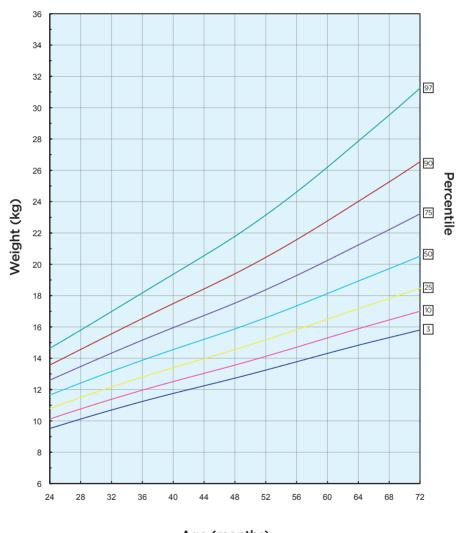
### PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



Age (months)



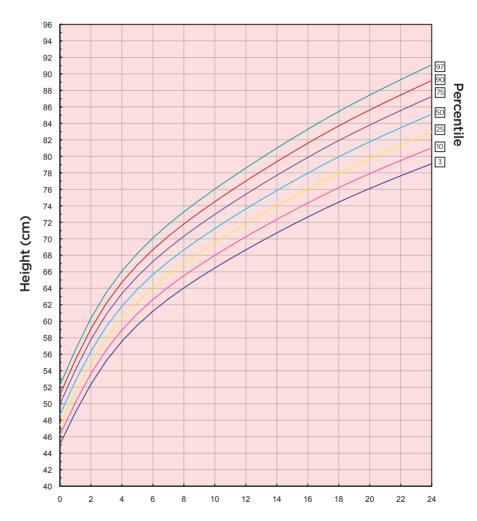
### PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 24 TO 72 MONTHS



Age (months)



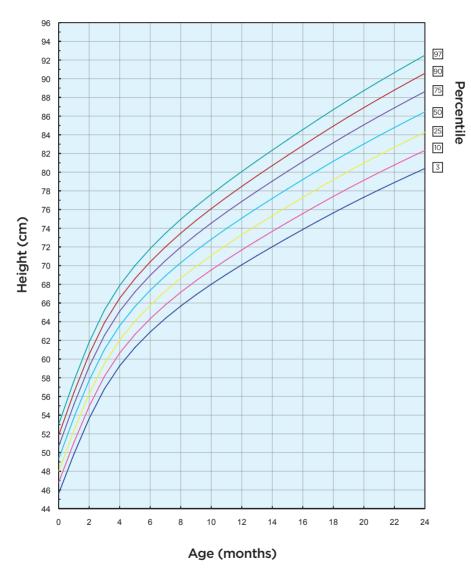
# PERCENTILES OF HEIGHT-FOR-AGE GIRLS AGED 0 TO 24 MONTHS



Age (months)

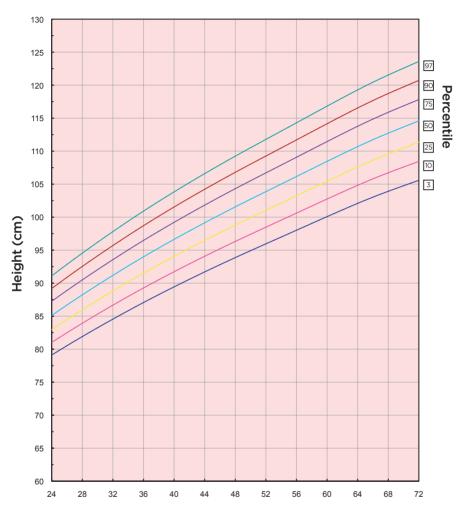


# PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS





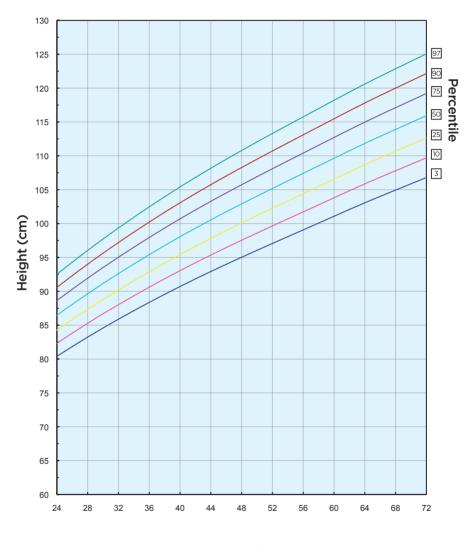
# PERCENTILES OF HEIGHT-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



Age (months)



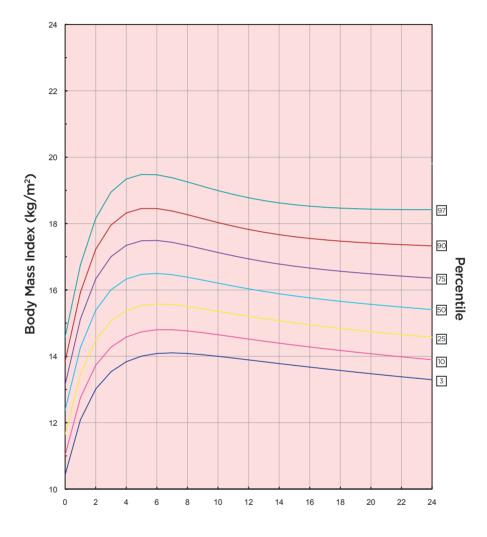
# PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 24 TO 72 MONTHS



Age (months)



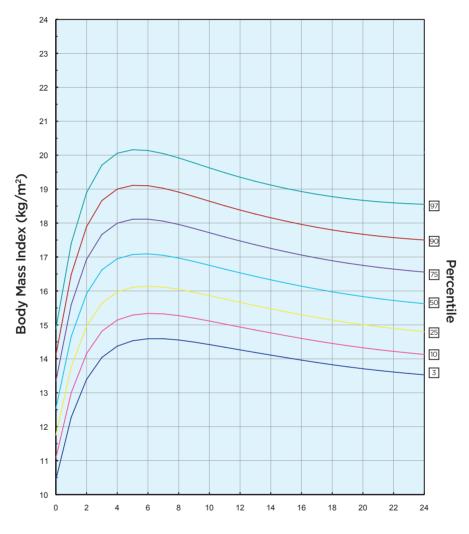
# PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 0-24 MONTHS



Age (months)



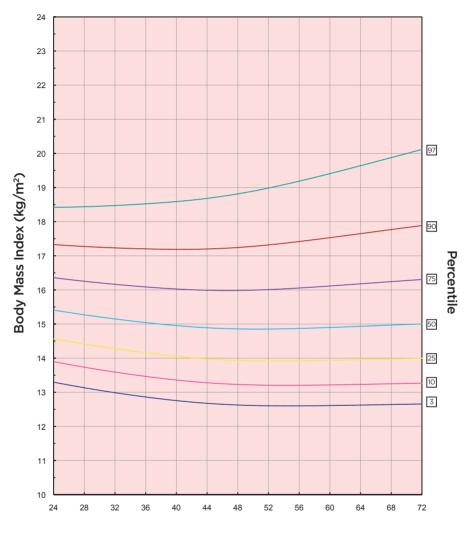
# PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 0-24 MONTHS



Age (months)



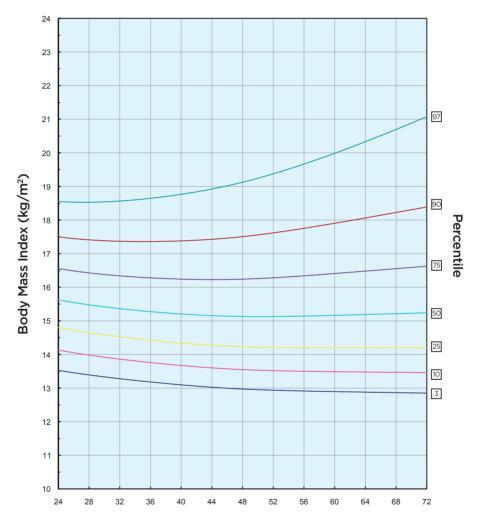
# PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 24-72 MONTHS



Age (months)



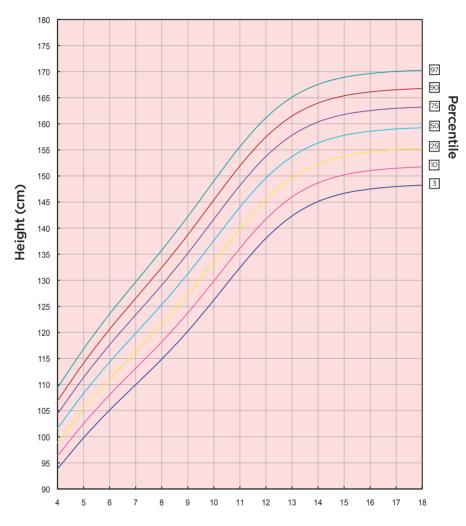
# PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 24-72 MONTHS



Age (months)



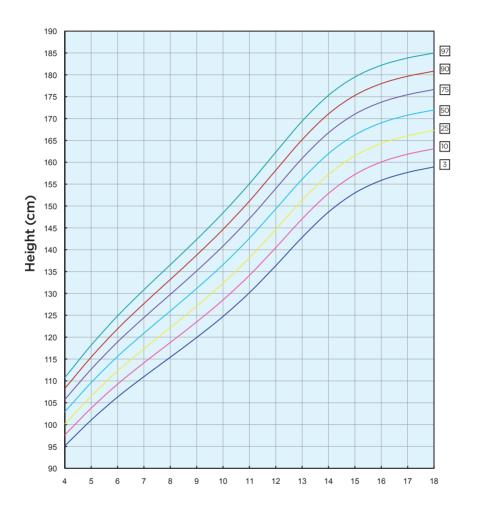
# PERCENTILES OF HEIGHT-FOR-AGE GIRLS AGED 4 TO 18 YEARS



Age (years)



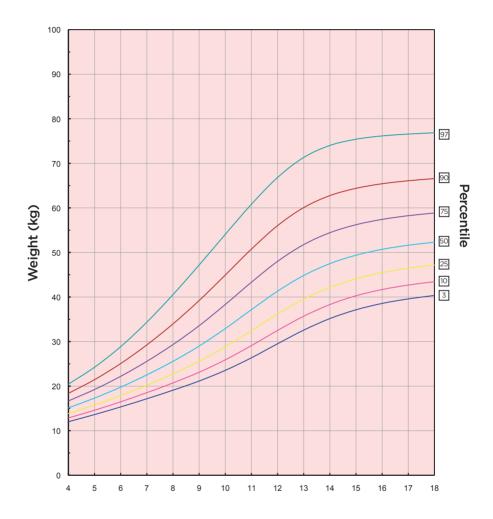
# PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 4 TO 18 YEARS



Age (years)



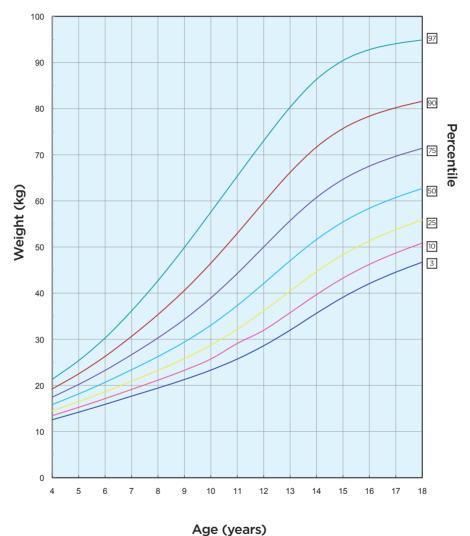
# PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 4 TO 18 YEARS



Age (years)

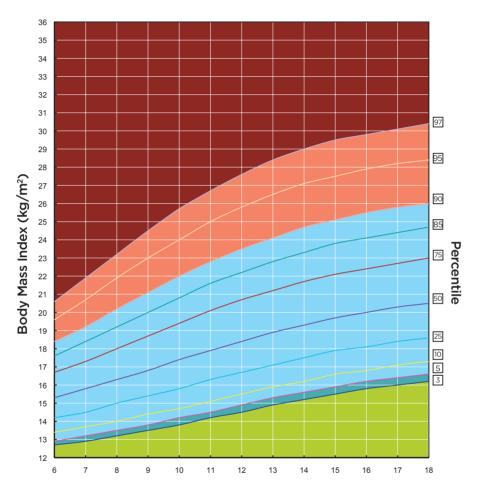


# PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 4 TO 18 YEARS





## PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 6 TO 18 YEARS

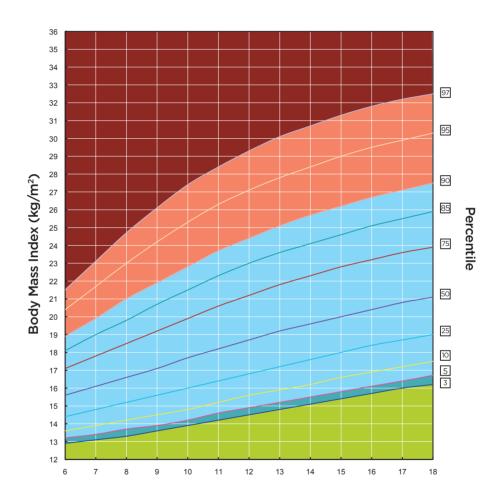


### Age (years)

≥ 97<sup>th</sup> Percentile : Severely Overweight
90<sup>th</sup> to <97<sup>th</sup> Percentile : Overweight
5<sup>th</sup> to <90<sup>th</sup> Percentile : Acceptable Weight
3<sup>rd</sup> to <5<sup>th</sup> Percentile : Underweight
< 3<sup>rd</sup> Percentile : Severely Underweight
< Severely Underweight



## PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 6 TO 18 YEARS



# Age (years)

≥ 97<sup>th</sup> Percentile : Severely Overweight
90<sup>th</sup> to <97<sup>th</sup> Percentile : Overweight
5<sup>th</sup> to <90<sup>th</sup> Percentile : Acceptable Weight
3<sup>rd</sup> to <5<sup>th</sup> Percentile : Underweight
< 3<sup>rd</sup> Percentile : Severely Underweight

BMI-for-age for GIRLS aged 6-18 years

Weight Indicator	Severely Underweight	Underweight	Acceptable Weight	Overweight	Severely Overweight
Age (years)	< 3rd percentile	3rd - <5th percentile	5th - <90th percentile	90th - <97th percentile	≥97th percentile
9	≥ 12.6	12.7 - 12.8	12.9 - 18.3	18.4 - 20.5	≥ 20.6
7	≥ 12.8	12.9 - 13.1	13.2 - 19.1	19.2 - 21.8	≥ 21.9
8	≥ 13.1	13.2 - 13.4	13.5 - 20.1	20.2 - 23.1	≥ 23.2
6	s 13.4	13.5 - 13.7	13.8 - 21.0	21.1 - 24.4	≥ 24.5
10	s 13.7	13.8 - 14.1	14.2 - 21.9	22.0 - 25.6	≥ 25.7
11	s 14.1	14.2 - 14.4	14.5 - 22.7	22.8 - 26.6	≥ 26.7
12	≥ 14.4	14.5 - 14.8	14.9 - 23.4	23.5 - 27.5	≥ 27.6
13	≥ 14.8	14.9 - 15.2	15.3 - 24.0	24.1 - 28.3	≥ 28.4
14	≥ 15.1	15.2 - 15.5	15.6 - 24.6	24.7 - 28.9	≥ 29.0
15	≥ 15.4	15.5 - 15.8	15.9 - 25.0	25.1 - 29.4	≥ 29.5
16	≥ 15.7	15.8 - 16.1	16.2 - 25.4	25.5 - 29.7	≥ 29.8
41	≥ 15.9	16.0 - 16.3	16.4 - 25.7	25.8 - 30.0	≥ 30.1
18	≥ 16.1	16.2 - 16.5	16.6 - 25.9	26.0 - 30.3	≥ 30.4

Anthropometric Study on School Children in Singapore, 2002 Health Promotion Board

BMI-for-age for BOYS aged 6-18 years

Severely Overweight	≥97th percentile	> 21.5	> 23.1	> 24.7	> 26.1	> 27.4	> 28.4	> 29.3	> 30.1	> 30.7	> 31,3	> 31.8	> 32.2	> 32.5
Overweight	90th - <97th percentile	18.9 - 21.4	19.9 - 23.0	21.0 - 24.6	21.9 - 26.0	22.8 - 27.3	23.7 - 28.3	24.4 - 29.2	25.1 - 30.0	25.6 - 30.6	26.2 - 31.2	26.6 - 31.7	27.1 - 32.1	27.5 - 32.4
Acceptable Weight	5th - <90th percentile	13.2 - 18.8	13.4 - 19.8	13.7 - 20.9	13.9 - 21.8	14.2 - 22.7	14.6 - 23.6	14.9 - 24.3	15.2 - 25.0	15.5 - 25.5	15.9 - 26.1	16.2 - 26.5	16.4 - 27.0	16.7 - 27.4
Underweight	3rd - <5th percentile	12.9 - 13.1	13.1 - 13.3	13.3 - 13.6	13.6 - 13.8	13.9 - 14.1	14.2 - 14.5	14.5 - 14.8	14.8 - 15.1	15.1 - 15.4	15.4 - 15.8	15.7 - 16.1	16.0 - 16.3	16.2 - 16.6
Severely Underweight	< 3rd percentile	≥ 12.8	≥ 13.0	s 13.2	≥ 13.5	≥ 13.8	≥ 14.1	≥ 14.4	s 14.7	≥ 15.0	≥ 15.3	≥ 15.6	≥ 15.9	≥ 16.1
Weight Indicator	Age (years)	9	7	80	6	10	11	12	13	14	15	16	17	18

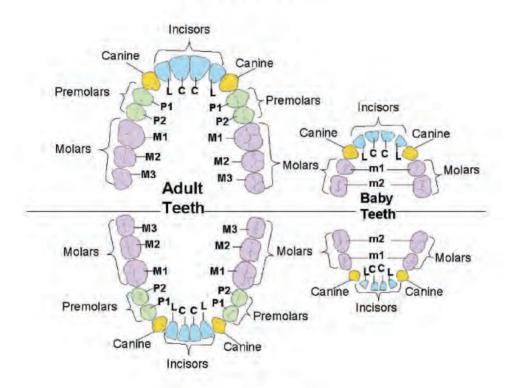
Anthropometric Study on School Children in Singapore, 2002 Health Promotion Board

# ORAL HEALTH INFORMATION EXPECTED AGE OF TOOTH ERUPTION

		тоотн	EXPECTED AGE OF TOOTH ERUPTION (mths)
Ξ	С	Central Incisor	6-8
ВАВҮ ТЕЕТН	L	Lateral Incisor	7-9
ABY		Canine	16-18
m	m1	First Molar	12-14
	m2	Second Molar	20-30

		тоотн	EXPECTED AGE OF TOOTH ERUPTION (years)
	С	Lower Central Incisor	6-7
	С	Upper Central Incisor	7-8
	L	Lower Lateral Incisor	7-6
E	L	Upper Lateral Incisor	8-9
ADULT TEETH		Lower Canine	9-10
DOL.		Upper Canine	11-12
⋖	P1	First Premolar	10-12
	P2	Second Premolar	
	M1	First Molar	6-7
	M2	Second Molar	11-13
	М3	Third Molar	17-21

# **UPPER TEETH**



LOWER TEETH

# CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)

1.	4-8 weeks
	I ensure that bolsters, pillows, blankets and plastic bags are kept away from my baby to avoid unintentional suffocation. I always place my baby to sleep on his back.
	I do not use a sarong cradle for my child nor allow him/her to sleep on the same bed as me, to avoid rolling onto and suffocating him/her. My baby sleeps in a cot which meets safety standards.
	When preparing the water for my child's bath, I run cold water into the bathtub first followed by hot water, to prevent scalds.
	I never leave my baby unattended in the bathtub.
	I ensure that my baby is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
	I never leave my baby alone in the car.
2.	3-5 months
	I ensure that bolsters, pillows, blankets and plastic bags are kept away from my baby to avoid unintentional suffocation. I always place my baby to sleep on his back.
	I do not use a sarong cradle for my child. My baby sleeps in a cot which meets safety standards.
	I ensure that my baby is never left alone on the bed or in a cot without the sides drawn up.
	I never leave my baby unattended in the bathtub.
	I ensure that my baby is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
	I never leave my child alone in the car.
3.	6-12 months
	I ensure that small toy parts and other choking hazards (e.g. coins, pins and buttons) are kept out of my child's reach.
	I never let my child use a baby walker.
	I ensure that the window grilles in my home are kept locked at all times.
	I make sure that my child is never left alone on the bed, in a cot without the sides drawn up, or in a high chair.
	I keep hot drinks and foods out of my child's reach. I use table mats instead of table cloths.
	I do not store pails of water in my bathroom.
	I ensure that my child is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
	I never leave my child alone in the car.

# **CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)**

4.	15-18 months
	I ensure that small toy parts and other choking hazards (e.g. coins, pins and buttons) are kept out of my child's reach.
	I do not give my child foods such as whole fish balls, whole grapes etc. that may cause choking.
	I have corner guards placed on tables with sharp edges.
	I have covered electrical outlets that are within my child's reach and ensure that wires and cords are secured to prevent tripping.
	I keep all floors dry as wet floors may cause my child to slip and fall.
	I limit my child's access to stairs by using a safety gate.
	I ensure that the window grilles in my home are kept locked at all times.
	I keep hot drinks and foods out of my child's reach. I use table mats instead of table cloths.
	I do not allow my child to enter the kitchen.
	I do not store pails of water in my bathroom.
	I always supervise my child closely near water, including bathtubs, swimming pools and open bodies of water.
	I ensure that my child is safely belted in an age-appropriate car seat placed in the back seat when travelling in a car.
	I never leave my child alone in the car.
5.	2-3 years
	I do not give my child foods such as whole fish balls, whole grapes etc. that may cause choking.
	I ensure that the following are kept out of my child's reach:
	small toy parts and other choking hazards (e.g. coins, pins and buttons)
	glassware, sharp tools, electrical equipment, matches, lighters, ashtrays and alcohol
	all medicines and household chemicals (which should be stored in child-proof containers or locked cupboards)
	I do not allow my child to play with plastic bags to avoid suffocation.
	I ensure that the window grilles in my home are kept locked at all times.
	I do not allow my child to enter the kitchen.
	I use non-slip mats in the bathroom.
	I always supervise my child closely near water, including bathtubs, swimming pools and open bodies of water.

# **CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)**

	I ensure that my child is safely belted in an age-appropriate car seat placed in the back seat when travelling in a car.
	I never leave my child alone in the car.
	I hold on to my child or carry him/her at all times while walking along or crossing the road.
6.	4-6 years
	I keep a close watch on my child when in the kitchen, especially when I am cooking.
	I ensure that all window grilles and doors cannot be opened by my child and that he/she is supervised in the balconies and near windows.
	I store all medicines and household chemicals in child-proof containers, keeping these as well a cleaning products out of my child's reach.
	I never leave my child alone at home.
	I ensure that my child always wears a helmet whenever he/she rides a bicycle, or goes roller blading. I never allow my child to cycle, or roller blade in car parks or on the streets.
	I hold on to my child at all times while walking along or crossing the road.
	I always supervise my child closely near water, including swimming pools and open bodies of water, even though he/she may know how to swim.
	I supervise my child closely while in the playground, and ensure he/she uses only equipment that is appropriate to his/her age.
	I ensure that my child is safely belted in an age-appropriate booster seat when travelling in a car.
	I never leave my child alone in the car.

Some useful numbers to keep in mind:

- **995** (For ambulance/fire service)
- **1777** (For non-emergency ambulance service)
- 1800 223 1313 (HPB's HealthLine for general advice)
- **1900 556 8773** (KK Ask-A-Nurse Service-chargeable)

Telephone numbers are valid at the time of revision.

National Childhood Immunisation Schedule, Singapore

Vaccination against	Birth	1 month	3 months	4 months	5 months	6 months	12 months	15 months	18 months	10-11 years^
Tuberculosis	BCG									
Hepatitis B	HepB (D1)	HepB (D2)			He G	HepB (D3)#				
Diphtheria, Tetanus, Pertussis			DTaP (D1)	DTaP (D2)	DTaP (D3)				DTaP (B1)	Tdap (B2)
Poliovirus			VG()	IPV (D2)	IPV (D3)				IPV (B1)	OPV (B2)
Haemophilus influenzae type b			원 (D)	Hib (D2)	Hib (D3)				Hib (B1)	
Measles, Mumps, Rubella							MMR (D1)	Ø ₩	MMR (D2)##	
Pneumococcal Disease			PCV (D1)		PCV (D2)		PCV (B1)			
Human Papillomavirus	Recon	nmended f	Recommended for females 9 to 26 years; three doses are required at intervals of 0, 2, 6 months	9 to 26 ye.	ars; three α	doses are r	equired at	intervals o	f 0, 2, 6 m	onths

# Notes:

BCG	BcG Bacillus Calmette-GuÈrin vaccine	PCV	Pneumococcal conjugate vaccine
НерВ	Hepatitis B vaccine	D1/D2/D3	<b>D1/D2/D3</b> 1st dose, 2nd dose, 3rd dose
<b>DТаР</b>	Paediatric diphtheria and tetanus toxoid and acellular pertussis vaccine	B1/B2	1st booster, 2nd booster
Тдар	Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine	<b>,</b>	Primary 5
MMR	Measles, mumps, and rubella vaccine	#	3rd dose of HepB can be given with the 3rd dose of DIaP, IPV and Hib for the convenience of parents
OPV	Oral polio vaccine	##	2nd dose of MMR can be given between 15-18 months
IPV	Inactived polio vaccine		
ם	Haemophilus influenzae type b vaccine		

# Immunisation for Diphtheria and Measles are COMPULSORY by law.

The National Immunisation Registry (NIR) maintains the immunisation records for all Singapore Residents aged 18 years and below. Parents can view their child's immunisation records at the NIR website www.nir.hpb.gov.sg. NIR uses the SingPass password for authentication.

The National Childhood Immunisation Programme has been implemented based on recommendations of the Expert Committee on Immunisation, comprising of senior officials from Ministry of Health, consultant paediatricians and experts in communicable disease control.

There are optional vaccines which are not part of the National Immunisation Schedule. Enquiries about these optional vaccines can be made through your family doctor, polyclinic or specialist.

For more immunisation information and updates, please check http://www.nir.hpb.gov.sg/nii/sv/eservices/ese

# Immunisation Record Of National Childhood Vaccinations

(To be completed by the doctor/nurse giving immunisation)

"Every medical practitioner shall within 7 days of a vaccination make a notification thereof in the prescribed form to any officer of the Health Promotion Board who is designated by the Director of Medical Services for the purpose, and deliver the duplicate copy of the notification to the person on whom the vaccination or intradermal test was carried out or, if such person is a child, to the parent or guardian of such child."

# Infectious Disease Act

Vaccine	Sequence	Site of Vaccination	Brand of Vaccine <sup>1</sup>	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
BCG						
Hepatitis B <sup>2</sup>	1st Dose					
(e.g. Erigerix-b, Infanrix-Hexa)	2 <sup>nd</sup> Dose					
	3 <sup>rd</sup> Dose					
Diptheria Dertuccie Tetanuc <sup>2</sup>	1st Dose					
(e.g. DTap, Infanrix, Infanrix-Hexa, Infanrix-	2 <sup>nd</sup> Dose					
Hib, Infanrix-IPV+Hib)	3 <sup>rd</sup> Dose					
	1st Booster					
	2 <sup>nd</sup> Booster					
<b>Polio²</b> (e.g. Polio Sabin, IPV,	1st Dose					
Infanrix Hexa, Infanrix- IPV+Hib)	2 <sup>nd</sup> Dose					
	3 <sup>rd</sup> Dose					
	1st Booster					
	2 <sup>nd</sup> Booster					
					_	

emophilus	1st Dose			
(e.g. Infanrix-Hib, Infanrix Hexa)	2 <sup>nd</sup> Dose			
	3 <sup>rd</sup> Dose			
	1st Booster			
ieumococcal	1st Dose			
(e.g. Synflorix, Prevenar 13)	2 <sup>nd</sup> Dose			
	3rd Dose (if needed)			
	Booster			
Measles, Mumps, Rubella	1st Dose			
g. M-M-R II, Prionx, orix-Tetra)	2 <sup>nd</sup> Dose/Booster			
Human Papilloma Virus				
(e.g. Gardasil, Cervarix) Recommended				
				1

# CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnote:

How to complete this record ... To Record the generic abreviation (e.g. Talap) or the trade name for each vaccine under the "Brand of Vaccine".

2. Fill in the respective inclination in the combination vaccines in the appropriate rows.

3. Please fill in under "Site of vaccination" - "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh "right", "right", "right and "right", "

# **Immunisation Record Of Optional Vaccinations**

Vaccine	Sequence	Site of Vaccination	Brand of Vaccine <sup>1</sup> Date Given	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Rotavirus		Oral				
(e.g. Rotarıx, Rotateq)		Oral				
		Oral				
Chicken Pox <sup>2</sup>						
(A)						
Hepatitis A <sup>2</sup>						
Meningococcus (e.g. Mencevax ACWY,						
Menactra)						
Influenza						
Others (Specify)						

# CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnote:

How to complete this record

1. Record the generic abbreviation (e.g. Tdap) or the trade name for each vaccine under the "Band of Vaccine".

2. Fill in the respective inclividual antigen in the combination vaccines in the appropriate rows.

3. Please fill in under "Sie of vaccination" - "left detod", "right detode", "left anterolateral thigh", "right anterolateral thigh", "right buttock", or "right buttock".

Summary of Clinic / Hospital Medical Records

Name and Signature of Doctor								
Management								
Diagnosis								
Clinic/Hospital								
Date								

Summary of Clinic / Hospital Medical Records

Name and Signature of Doctor								
Management								
Diagnosis								
Clinic/Hospital								
Date								

Summary of Clinic / Hospital Medical Records

Name and Signature of Doctor								
Management								
Diagnosis								
Clinic/Hospital								
Date								

Summary of Clinic / Hospital Medical Records

Name and Signature of Doctor								
Management								
Diagnosis								
Clinic/Hospital								
Date								

# **Appointment Dates**

(Remember to bring your Health Booklet when you visit your doctor/ Nurse/ Other Healthcare Professional)

Please remember to keep your appointments. If you missed or would like to change an appointment, please call the respective clinic to arrange for another one.

Date	Type of Appointment												
Date	Time	Immunisation	Development Screening	Health Education									

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- Thomson Medical Centre