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

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.

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, and ensure that health information such as immunisation records, allergies and any other medical conditions are updated promptly by the attending professional. This booklet is a personalized data bank of health and medical records of your child, allowing for medical history to be retrieved instantly should there be a need.

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:

- **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 complications.

- **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.

- **Childhood Health Behaviours Checklist (CHBC)**: These checklists have been designed based on local guidelines to support you in nurturing your child's healthy development across four key lifestyle domains: Screen Use, Sleep, Physical Activity, and Nutrition. The CHBC has been incorporated into the Childhood Developmental Screening checkpoints in support of the Grow Well SG initiative. Please complete these checklists before each appointment to help reflect your child's habits and facilitate discussions with healthcare professionals. There are additional resources provided in QR codes and weblinks to support you in your child's healthy development.

- **Child Safety Checklist**: This checklist will help you to create a child-friendly and safe environment for your child.

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 checks, and the administration of required childhood vaccinations.

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!

In support of

Grow Well SG

National Childhood Immunisation Schedule
(From birth to age 17 years, effective from 1 November 2020)

● **Recommended ages and doses for all children**

▲ **Recommended for children with specific medical condition or indication**

*D1 refers to Dose 1, D2 refers to Dose 2, D3 refers to Dose 3. B1 refers to Booster 1, B2 refers to Booster 2

At birth: D1 for BCG and HepB

2 months: D2 for HepB, and D1 for DTap, IPV and Hib as part of 6-in-1.

4 months: D2 for DTaP, IPV, Hib as part of 5-in-1. D1 for PCV.

● Influenza. Annual vaccination or per season for all children age **6 months to <5 years (59 months)**.

6 months: D3 for DTaP, IPV, Hib and HepB as part of 6-in-1. D2 for PCV.

12 months: B1 for PCV. D1 for MMR and Varicella.

15 months: D2 for MMR and Varicella as part of MMRV.

18 months: B1 for DTaP, IPV and Hib as part of 5-in-1.

▲ PPSV23. One or two doses for children and adolescents age **2 to 17 years with specific medical condition or indication**.

▲ Influenza. Annual vaccination or per season for children and adolescents age **5 to 17 years with specific medical condition or indication**.

10-11 years: B2 for Tdap and IPV

12-13 years: D1 for HPV (Females)

13-14 years: D2 for HPV (Females)

4 - 8 weeks	3 - 5 months	6 - 12 months	15 - 22 months	2 - 3 years	4 - 5 years	10 - 13 years	14 - 17 years
4 weeks Age range: 4-8 weeks	**3 months or 4 months**[1] Age range: 3-5 months	**6 months** **12 months** Age range: 6-12 months	**18 months** Age range: 15-22 months	**30 months** Age range: 24-36 months	**48 months** Age range: 48-60 months		

[1] Clinicians may wish to conduct the CDS together with vaccinations at 3 months old for children starting on 5-in-1(DTaP/IPV/Hib) schedule, and at 4 months for children starting on the 6-in-1 schedule.

7 Recommended Touchpoints for Childhood Developmental Screening

INFORMATION ON ALLERGIES

(To be completed by doctor)

No.	Item(s) that the child is allergic to	Type of allergic reaction (e.g. anaphylaxis, urticaria)	Please tick as appropriate		Date	Name of Doctor	Signature
			Confirmed Allergy	Suspected Allergy			

CONTENTS

SECTION 1

SECTION 2

SECTION 3

SECTION 4

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 Ethnic 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 OF PARENTS

MOTHER

Name: _____ NRIC/Passport No.: _____

Email: _____ Occupation: _____

Tel (RES): _____ Tel (OFF): _____ Tel (HP): _____

FATHER

Name: _____ NRIC/Passport No.: _____

Email: _____ Occupation: _____

Tel (RES): _____ Tel (OFF): _____ Tel (HP): _____

SIGNIFICANT EVENTS DURING PREGNANCY / DELIVERY

Jaundice ☐ No ☐ Yes **Phototherapy** ☐ Yes **Exchange Transfusion** ☐ Yes

NEWBORN SCREENING

G6PD Deficiency ☐ No ☐ Yes

TSH: _____ mIU/L **fT4:** _____ pmol/L Date: _____

***IEM Screening Done** ☐ No ☐ Yes Date: _____

Hearing Screening

☐ ** **OAE** Date: _____ ☐ *** **ABAER** Date: _____

Left Pass: ☐ No ☐ Yes Left Pass: ☐ No ☐ Yes

Right Pass: ☐ No ☐ Yes Right Pass: ☐ No ☐ Yes

Needs further evaluation: ☐ No ☐ Yes

Remarks (if any): _____

INVESTIGATION(S) DONE (IF ANY)

Serum Bilirubin (highest level) : _____ µmol/L Date: _____

Blood Group: _____ Date: _____

Other Tests: (please specify)

_____ _____ Date: _____

_____ _____ Date: _____

INFORMATION ON DISCHARGE FROM HOSPITAL

Date: _____ Weight: ☐☐☐☐ gm Breast Feeding: ☐ Yes ☐ No

Serum Bilirubin (if done) before discharge : _____ µmol/L

Instructions to doctors and nurses:
All weight, length and head circumference measurements are to be entered on the charts on pages 29-52
Please document additional medical findings in the summary of clinic/hospital medical record section on pages 64-66
*IEM =Inborn Errors of Metabolism, **OAE= Oto-Acoustic Emission, and ***ABAER= Automated Brainstem Auditory Evoked Response.

SUMMARY OF RECOMMENDED TOUCHPOINTS FOR CHILDHOOD DEVELOPMENTAL SCREENING AND NCIS VACCINATIONS

AGE	TYPE OF SCREENING^	IMMUNISATION
At Birth	–	BCG (Dose 1) Hep B (Dose 1)
4 weeks	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Hearing screening if not done at birth 4. Physical examination and developmental check on page 7 – 8 • To also focus on identifying any issues related to: (i) Congenital cataract (ii) Cardiac murmurs (iii) Prolonged jaundice (iv) Hip dysplasia (v) Abnormal growth monitoring (vi) Feeding issues (e.g. parent reported difficulties with breast or bottle feeding, vomiting/reflux)	–
2 months	–	6-in-1 (Dose 1)**
3 months **OR** **4 months**	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Test for squint 4. Hearing screening if not done at birth/4-8 weeks 5. **Parents/caregivers please answer the questions below*****: • Can your child keep his/her head upright when held in a sitting position? Yes/No • Can your child respond to the parent's/caregiver's voice by quietening down if crying or smiling? Yes/No • Can your child visually follow the parent's/caregiver's movements, including turning his/her head from side to side? Yes/No 6. Physical examination and developmental check on page 9 - 11	– 5-in-1 (Dose 2) PCV (Dose 1)
6 months	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. **Parents/caregivers please answer the questions below*****: • Can your child roll over? Yes/No • Can your child turn towards a sound? Yes/No • Can your child reach out for things? Yes/No 4. Physical examination and developmental check on page 12 – 14	6-in-1 (Dose 3) PCV (Dose 2) Influenza****

Legend: ^**The recommended CDS touchpoints are at 4 weeks, 3 months or 4 months, 6 months, 12 months, 18 months, 30 months and 48 months.** For the second touchpoint, the recommended touchpoint is at 3 months for children starting on the 5-in-1 vaccine schedule and 4 months for children starting on the 6-in-1 vaccine schedule. The 5-in-1 vaccine includes DTaP, IPV and Hib. The 6-in-1 vaccine comprises components in 5-in-1 plus HepB. Refer to Section 3 for more information on immunisation.

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

** For infants born to **HBsAg +ve** mothers, HepB dose 2 is recommended at **1 month** using monovalent HepB vaccine. 5-in-1 dose 1 is recommended at 2 months.

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

**** Annual flu vaccination or per season for all children age **6 months to <5 years (59 months).**

SUMMARY OF RECOMMENDED TOUCHPOINTS FOR CHILDHOOD DEVELOPMENTAL SCREENING AND NCIS VACCINATIONS

AGE	TYPE OF SCREENING^	IMMUNISATION
12 months	1. Growth monitoring: weight, length, OFC* 2. Feeding history 3. Test for squint 4. **Parents/caregiver please answer the questions below*****: • Can your child wave bye-bye or clap hands? Yes/No • Can your child say Papa or Mama? Yes/No • Can your child stand alone for 2 or more seconds without support? Yes/No • Can your child walk a few steps? Yes/No • Does your child have a pincer grasp? Yes/No • Does your child babble, point or use gestures? Yes/No • Does your child respond readily to affection? Yes/No 5. Physical examination and developmental check on page 15 – 17	PCV (Booster 1) MMR (Dose 1) Varicella (Dose 1)
15 months	1. Growth monitoring: weight, height, OFC* 2. Physical examination and developmental check on page 18 – 20	MMRV (Dose 2)
18 months	1. Growth monitoring: weight, height, OFC* 2. Test for squint 3. **Parents/caregivers please answer the questions below*****: • Can your child 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? Yes/No • Can you child say at least three words other than "Papa/Mama", which mean the same things each time he uses them? Yes/No 4. Physical examination and developmental check on page 18 – 20	5-in-1 (Booster 1)
30 months	1. Growth monitoring: weight, height, OFC, BMI 2. Test for squint 3. **Parents/Caregivers please answer the questions below*****: • Can your child climb stairs without assistance? Yes/No • Can your child speak spontaneously in sentences with 4 syllables? Yes/No 4. Physical examination and developmental check on page 21 – 24	–
48 months	1. Growth monitoring: weight, height, BMI 2. Visual acuity and test for squint 3. Stereopsis 4. Physical examination and developmental check on page 25 – 28	–

Legend: ^**The recommended CDS touchpoints are at 4 weeks, 3 months or 4 months, 6 months, 12 months, 18 months, 30 months and 48 months.** For the second touchpoint, the recommended touchpoint is at 3 months for children starting on the 5-in-1 vaccine schedule and 4 months for children starting on the 6-in-1 vaccine schedule. The 5-in-1 vaccine includes DTaP, IPV and Hib. The 6-in-1 vaccine comprises components in 5-in-1 plus HepB. Refer to Section 3 for more information on immunisation.

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

** For infants born to **HBsAg +ve** mothers, HepB dose 2 is recommended at **1 month** using monovalent HepB vaccine. 5-in-1 dose 1 is recommended at 2 months.

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

**** Annual flu vaccination or per season for all children age **6 months to <5 years (59 months).**

SCREENING AT 4 WEEKS TO 8 WEEKS

Date of Screening: _____ Age: _____ Main caregiver: _____

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 When you face your baby lying on his back, he looks at you and watches you. (Regards face)	☐	☐	1
2 When you talk and smile to your baby, he smiles back at you without you tickling or touching him. (Smiles spontaneously)	☐	☐	1
Fine Motor-Adaptive			
3 When your child is on his back, he can follow the movement of an object, from one side to facing directly forwards. (Follows to mid-line)	☐	☐	1.5
4 When your child is on his back, he can follow the movement of an object, from one side, past the mid-line to the other side. (Follows past mid-line)	☐	☐	2.5
Language			
5 When your child hears a bell sound that he cannot see, i.e. outside his line of vision, he responds with eye movements, changes in breathing pattern or changes in activities. (Responds to a bell)	☐	☐	1
6 Your child makes sounds other than crying, such as small throaty sounds or short vowels sounds like "UH", "OO", "EH", "AH"...(Vocalises)	☐	☐	1.5
Gross Motor			
7 While your child is lying on his back, he moves his arms and legs equally. (Equal movement)	☐	☐	1
8 When your child is placed on his stomach, he lifts his head momentarily off the surface. (Lifts head)	☐	☐	1
9 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. (Holds head up – 45 degrees)	☐	☐	3

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

_____

_____

SCREENING AT 4 WEEKS TO 8 WEEKS

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use			
1	You avoid giving your child any screen time* from any type of devices such as smartphones, tablets, laptops and television. **Includes screen time during feeds, before bed and any time when your child is awake. Please exclude time spent on interactive video chatting.*	☐	☐
2	You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep			
3	Your child gets about 14-17 hours of sleep daily (including nap time).	☐	☐
Physical Activity			
4	Your child is engaged in interactive floor-based activities* (non-screen-based) for a minimum of 30 minutes spread throughout the day. **Includes supervised tummy time.*	☐	☐

SCREENING AT 4 WEEKS TO 8 WEEKS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**	**YES/ MOST OF THE TIME**	**NO/ RARELY**
Nutrition		
5 Your child is breastfed as much as possible.	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed 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, INFANT SHOULD BE REFERRED TO A HOSPITAL FOR HEARING TEST)

☐ **Oto-acoustic emission (OAE)**

Date: _____

Left Pass: ☐ No ☐ Yes

Right Pass: ☐ No ☐ Yes

☐ **Automated Brainstem Auditory Evoked Response (ABAER)**

Date: _____

Left Pass: ☐ No ☐ Yes

Right Pass: ☐ No ☐ Yes

Needs further evaluation: ☐ No ☐ Yes

Remarks (if any): _____

PHYSICAL EXAMINATION

Eye Examination: Fixation on moving 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 tone**
	☐ **Ears**	☐ **Abdomen**	☐ **Legs**	☐ **Back**
	☐ **Mouth/Palate**	☐ **Umbilicus**	☐ **Hips**	☐ **Skin**
	☐ **Neck**	☐ **Femoral pulses**		
Reflexes:	☐ **Moro**	☐ **Grasp**	☐ **Tonic Neck**	☐ **Walking/Stepping**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 3 MONTHS TO 5 MONTHS

Date of Screening: _____ Age: _____ Main caregiver: _____

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 When you face your baby lying on his back, he looks at you and watches you. (Regards face)	☐	☐	1
2 When you talk and smile to your baby, he smiles back at you without you tickling or touching him. (Smiles spontaneously)	☐	☐	1
3 Your child displays excitement like kicking legs, moving arms, on seeing an attractive toy. (Excites at a toy)	☐	☐	5.5
Fine Motor-Adaptive			
4 When the child is on his back, he can follow the movement of an object, from one side past the mid-line to the other side. (Follows past mid-line)	☐	☐	2.5
5 Your child can touch his own hands together at the mid-line of his body. (Hands together)	☐	☐	3.5
6 When you bring a rattle to touch the back or tips of your child's fingers, he grasps the rattle in the hand for a few seconds. (Grasps rattle in hand)	☐	☐	4
7 When your child is on his back, his eyes and head will follow the movement of an object from one side, past the mid-line and right over to the other side. (Follows 180 degrees)	☐	☐	4.5
8 Your child is able to focus on small objects like a raisin, placed in front of him on the table. (Regards a raisin)	☐	☐	5.5
Language			
9 When your child hears a bell sound that he cannot see, i.e. outside his line of vision, he responds with eye movements, changes in breathing pattern or changes in activities. (Responds to a bell)	☐	☐	1
10 Your child makes sounds other than crying, such as small throaty sounds or short vowels sounds like "UH", "OO", "EH", "AH"...(Vocalises)	☐	☐	1.5
11 Your child laughs out loud without being tickled. (Laughs)	☐	☐	4.5
12 Your 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

SCREENING AT 3 MONTHS TO 5 MONTHS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	**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. (Holds 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 (Singapore) has been amended.

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

SCREENING AT 3 MONTHS TO 5 MONTHS

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use			
1	You avoid giving your child any screen time* from any type of devices such as smartphones, tablets, laptops and television. **Includes screen time during feeds, before bed and any time when your child is awake. Please exclude time spent on interactive video chatting.*	☐	☐
2	You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep			
3	Your child gets about 14-17 hours of sleep daily at 3 months old and 12-15 hours of sleep daily at 4 to 5 months old (including nap time).	☐	☐
Physical Activity			
4	Your child is engaged in interactive floor-based activities* (non-screen-based) for a minimum of 30 minutes spread throughout the day. **Includes supervised tummy time and practising rolling over.*	☐	☐
Nutrition			
5	Your child is breastfed as much as possible.	☐	☐

SCREENING AT 3 MONTHS TO 5 MONTHS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
6	Your child (aged 4 months and above) has been introduced to a variety of developmentally appropriate solid foods of various textures and flavours, prepared with no added salt, sugar, oil, and other sauces and seasoning*. **If solid foods have been introduced into your child's diet (if not, please indicate as N.A.).*	☐	☐
7	You avoid giving your child any fruit juices, sugar- and artificially sweetened drinks*, and caffeinated beverages. **Examples include chocolate/malt drinks, canned or packaged drinks, or cola-flavoured soft drinks.*	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 3 MONTHS TO 5 MONTHS

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %

Length: _____ cm _____ %

HEARING SCREENING (IF NOT DONE AT BIRTH OR AT 4 WEEKS TO 8 WEEKS OLD, INFANT SHOULD BE REFERRED TO A HOSPITAL FOR HEARING TEST)

☐ **Oto-acoustic emission (OAE)**

Date: _____

Left Pass: ☐ No ☐ Yes

Right Pass: ☐ No ☐ Yes

Needs further evaluation: ☐ No ☐ Yes

☐ **Automated Brainstem Auditory Evoked Response (ABAER)**

Date: _____

Left Pass: ☐ No ☐ Yes

Right Pass: ☐ No ☐ Yes

Remarks (if any): _____

PHYSICAL EXAMINATION

Eye Examination: Fixation on moving object: Right eye ☐ Left eye ☐

Cornea/Lens ☐ Pupillary Light reflex ☐

Red Reflex ☐ Nystagmus: Yes ☐ No ☐

Squint: Yes ☐ No ☐

Roving Eye Movement: Yes ☐ No ☐

Eye Movements _____

☐ **Facies**	☐ **Heart**	☐ **Genitals**	☐ **Posture**
☐ **Fontanelles**	☐ **Lungs**	☐ **Arms**	☐ **Muscle tone**
☐ **Ears**	☐ **Abdomen**	☐ **Legs**	☐ **Back**
☐ **Mouth/Palate**	☐ **Umbilicus**	☐ **Hips**	☐ **Skin**
☐ **Neck**	☐ **Femoral pulses**		

Reflexes: ☐ **Moro** ☐ **Grasp** ☐ **Tonic Neck** ☐ **Walking/Stepping**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 6 MONTHS
(6 months - 12 months)

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL CONCERNS
Please inform your doctor if your child has ANY of these difficulties:
- Does not babble, point or use gestures by 12 months
- Has lost any language skills
- Does not respond readily to affection
- Has poor eye contact

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	**YES**	**NO**	**Age (mths) when 90% achieve the milestone**
Personal Social			
1 Your child displays excitement like kicking legs or moving arms, on seeing an attractive toy. (Excites at a toy)	☐	☐	**5.5**
2 Your child will try to get a toy that he enjoys when it is out of reach by stretching his arms or body. (Works for a toy out of reach)	☐	☐	**6.5**
3 Your child seems to be shy or wary of strangers. (Reacts to stranger)	☐	☐	**10**
4 When you face your child, say bye-bye and wave to him, he responds by waving his arm, hand or fingers without his hands or arms being touched. (Waves bye-bye)	☐	☐	**10.5**
5 When you clap your hands, your child responds by clapping his hands when you ask him to, without his hands or arms being touched. (Claps hands)	☐	☐	**11**
6 Your child can indicate what he wants without crying or whining. He may do this by pointing, pulling and making speech-like sounds or putting arms up to be carried without speaking. (Indicates wants by gestures)	☐	☐	**13.5**
Fine Motor-Adaptive			
7 When your child is on his back, his eyes and head will follow the movement of an object from one side, past the mid-line and right over to the other side. (Follows 180 degrees)	☐	☐	**4.5**
8 Your child is able to focus on small objects like a raisin, placed in front of him on the table. (Regards a raisin)	☐	☐	**5.5**
9 Your child can pick up a toy within his reach or reach out for things. (Reaches for an object)	☐	☐	**6**
10 Your child will look for an object that has fallen out of his line of vision when his attention is focused on that object. (Looks for a fallen object)	☐	☐	**7**
11 Your child can pass something small from one hand to the other hand. (Passes a cube from hand to hand)	☐	☐	**7.5**
12 Your child can pick up a raisin by bringing together any part of the thumb and any one finger. (Finger-Thumb Grasp)	☐	☐	**10**
13 When your child is holding a block in each hand, he is able to hit them together, without his hands or arms being touched by you. (Bangs 2 cubes held in hands)	☐	☐	**10.5**

SCREENING AT 6 MONTHS
(6 months - 12 months)

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	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
Language			
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
Gross 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

*The instruction from the Denver Developmental Screening Test (Singapore) has been amended.

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

SCREENING AT 6 MONTHS
(6 months - 12 months)

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**	**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use		
1 You avoid giving your child any screen time* from any type of devices such as smartphones, tablets, laptops and television. **Includes screen time during meals, before bed and any time when your child is awake. Please exclude time spent on interactive video chatting.*	☐	☐
2 You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep		
3 Your child gets about 12-15 hours of sleep daily at 6 to 11 months old, and 11-14 hours of sleep daily at 12 months old (including nap time).	☐	☐
Physical Activity		
4 Your child is engaged in interactive floor-based activities* (non-screen-based) for a minimum of 30 minutes spread throughout the day. **Includes supervised crawling and attempts to walk by holding onto furniture for support (cruising).*	☐	☐
Nutrition		
5 Your child has been introduced to a variety of developmentally appropriate solid foods of various textures and flavours, prepared with no added salt, sugar, oil, and other sauces and seasoning*. **If solid foods have been introduced into your child's diet (if not, please indicate as N.A.).*	☐	☐

SCREENING AT 6 MONTHS
(6 months - 12 months)

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
6	Your child's meals are spaced 2-3 hours apart to avoid overfeeding.	☐	☐
7	You avoid giving your child any fruit juices, sugar- and artificially sweetened drinks*, and caffeinated beverages. **Examples include chocolate/malt drinks, canned or packaged drinks, or cola-flavoured soft drinks.*	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 6 MONTHS
(6 months - 12 months)

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %

Length: _____ cm _____ %

OTHER SCREENING

Remarks (if any): _____

_____

_____

_____

PHYSICAL EXAMINATION (IF DEEMED NECESSARY)

Eye Examination: Fixation on moving object: Right eye ☐ Left eye ☐

Cornea/Lens ☐ Pupillary Light reflex ☐

Red Reflex ☐ Nystagmus: Yes ☐ No ☐

Squint: Yes ☐ No ☐

Roving Eye Movement: Yes ☐ No ☐

Eye Movements _____

☐ **Fontanelles**	☐ **Heart**	☐ **Femoral pulses**	☐ **Posture**
☐ **Ears**	☐ **Lungs**	☐ **Genitals**	☐ **Muscle tone**
☐ **Teeth**	☐ **Abdomen**	☐ **Hips**	☐ **Skin**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 12 MONTHS
(6 months - 12 months)

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL CONCERNS
Please inform your doctor if your child has ANY of these difficulties:
- Does not babble, point or use gestures by 12 months
- Has lost any language skills
- Does not respond readily to affection
- Has poor eye contact

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	**YES**	**NO**	**Age (mths) when 90% achieve the milestone**
Personal Social			
1 Your child displays excitement like kicking legs or moving arms, on seeing an attractive toy. (Excites at a toy)	☐	☐	**5.5**
2 Your child will try to get a toy that he enjoys when it is out of reach by stretching his arms or body. (Works for a toy out of reach)	☐	☐	**6.5**
3 Your child seems to be shy or wary of strangers. (Reacts to stranger)	☐	☐	**10**
4 When you face your child, say bye-bye and wave to him, he responds by waving his arm, hand or fingers without his hands or arms being touched. (Waves bye-bye)	☐	☐	**10.5**
5 When you clap your hands, your child responds by clapping his hands when you ask him to, without his hands or arms being touched. (Claps hands)	☐	☐	**11**
6 Your child can indicate what he wants without crying or whining. He may do this by pointing, pulling and making speech-like sounds or putting arms up to be carried without speaking. (Indicates wants by gestures)	☐	☐	**13.5**
Fine Motor-Adaptive			
7 When your child is on his back, his eyes and head will follow the movement of an object from one side, past the mid-line and right over to the other side. (Follows 180 degrees)	☐	☐	**4.5**
8 Your child is able to focus on small objects like a raisin, placed in front of him on the table. (Regards a raisin)	☐	☐	**5.5**
9 Your child can pick up a toy within his reach or reach out for things. (Reaches for an object)	☐	☐	**6**
10 Your child will look for an object that has fallen out of his line of vision when his attention is focused on that object. (Looks for a fallen object)	☐	☐	**7**
11 Your child can pass something small from one hand to the other hand. (Passes a cube from hand to hand)	☐	☐	**7.5**
12 Your child can pick up a raisin by bringing together any part of the thumb and any one finger. (Finger-Thumb Grasp)	☐	☐	**10**
13 When your child is holding a block in each hand, he is able to hit them together, without his hands or arms being touched by you. (Bangs 2 cubes held in hands)	☐	☐	**10.5**

SCREENING AT 12 MONTHS
(6 months - 12 months)

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	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
Language			
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
Gross 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

*The instruction from the Denver Developmental Screening Test (Singapore) has been amended.

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

SCREENING AT 12 MONTHS
(6 months - 12 months)

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**	**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use		
1 You avoid giving your child any screen time* from any type of devices such as smartphones, tablets, laptops and television. **Includes screen time during meals, before bed and any time when your child is awake. Please exclude time spent on interactive video chatting.*	☐	☐
2 You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep		
3 Your child gets about 12-15 hours of sleep daily at 6 to 11 months old, and 11-14 hours of sleep daily at 12 months old (including nap time).	☐	☐
Physical Activity		
4 Your child is engaged in interactive floor-based activities* (non-screen-based) for a minimum of 30 minutes spread throughout the day. **Includes supervised crawling and attempts to walk by holding onto furniture for support (cruising).*	☐	☐
Nutrition		
5 Your child has been introduced to a variety of developmentally appropriate solid foods of various textures and flavours, prepared with no added salt, sugar, oil, and other sauces and seasoning*. **If solid foods have been introduced into your child's diet (if not, please indicate as N.A.).*	☐	☐

SCREENING AT 12 MONTHS
(6 months - 12 months)

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
6	Your child's meals are spaced 2-3 hours apart to avoid overfeeding.	☐	☐
7	You avoid giving your child any fruit juices, sugar- and artificially sweetened drinks*, and caffeinated beverages. **Examples include chocolate/malt drinks, canned or packaged drinks, or cola-flavoured soft drinks.*	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 12 MONTHS
(6 months - 12 months)

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %

Length: _____ cm _____ %

OTHER SCREENING

Remarks (if any): _____

_____

_____

_____

PHYSICAL EXAMINATION (IF DEEMED NECESSARY)

Eye Examination: Fixation on moving object: Right eye ☐ Left eye ☐

Cornea/Lens ☐ Pupillary Light reflex ☐

Red Reflex ☐ Nystagmus: Yes ☐ No ☐

Squint: Yes ☐ No ☐

Roving Eye Movement: Yes ☐ No ☐

Eye Movements _____

☐ **Fontanelles**	☐ **Heart**	☐ **Femoral pulses**	☐ **Posture**
☐ **Ears**	☐ **Lungs**	☐ **Genitals**	☐ **Muscle tone**
☐ **Teeth**	☐ **Abdomen**	☐ **Hips**	☐ **Skin**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 15 MONTHS TO 22 MONTHS

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL CONCERNS
Please inform your doctor if your child has ANY of these difficulties:
- Does not babble, point or use gestures by 12 months
- Does not speak a single word by 18 months
- Has lost any language skills
- Does not respond readily to affection

Please answer the following and tick "NO" / "YES"
ALL FIELDS SHOULD BE COMPLETED

Have you any worries about your child's:	NO	YES	
• Health and growth	☐	☐	Specify: _____
• Diet and feeding	☐	☐	Specify: _____
• Sleep	☐	☐	Specify: _____
• Behaviour	☐	☐	Specify: _____

VISION
Does your child frown, tilt his head in order to see better or close one eye while looking into the distance in bright light? ☐ NO ☐ YES

HEARING
Does your child respond to sounds even when the source is not within his sight, e.g. calling of his name, ringing of the telephone? ☐ NO ☐ YES

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 Your child can indicate what he wants without crying or whining. He may do this by pointing, pulling and making speech-like sounds. (Indicates wants by gestures)	☐	☐	13.5
2 When you are doing housework, your child copies what you are doing. (Imitates household activities)	☐	☐	16
3 Your child can hold a regular cup himself and drink from it without spilling much. The cup should not have a spout. (Drinks from a cup)	☐	☐	18.5
Fine Motor Adaptive			
4 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
5 Your child can make purposeful markings on paper when you give him a pencil. (Scribbles)	☐	☐	16
6 Your child can put 2 or more blocks one on top of the other without the blocks falling. This applies to small blocks of about one inch square in size. (Builds a tower of 2 cubes)	☐	☐	17

SCREENING AT 15 MONTHS TO 22 MONTHS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	**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 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**
12 Your child can walk well with good balance, rarely falls and does not sway from side to side. (Walks well)	☐	☐	**16**
13 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 22 MONTHS

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use			
1	You avoid giving your child any screen time* from any type of devices such as smartphones, tablets, laptops and television. **Includes screen time during meals, before bed and any time when your child is awake. Please exclude time spent on interactive video chatting.*	☐	☐
2	You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep			
3	Your child has regular sleep and wake times and gets about 11-14 hours of sleep daily (including nap time).	☐	☐
Physical Activity			
4	Your child spends at least 180 minutes doing a variety of physical activities of any intensity spread throughout the day, including crawling, walking and running.	☐	☐
5	Your child engages in outdoor active play* daily. **For example, playing at outdoor playgrounds, playing catching/tag, ball games, and cycling in outdoor areas.*	☐	☐
Nutrition			
6	Your child has a structured routine* for meal and snack times daily. **This includes serving your child with meals at regular timings every day.*	☐	☐

SCREENING AT 15 MONTHS TO 22 MONTHS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
7	Your child is given an appropriate portion* of meal and snacks^ daily. **A quarter plate of wholegrains, a quarter plate of meat and other produce, and half a plate of fruits and vegetables.* *^Offer snacks in moderation. Recommended options include wholegrain foods, fruits and vegetables (e.g., wholegrain biscuits, carrot sticks).*	☐	☐
8	You avoid giving your child any fruit juices, sugar- and artificially sweetened drinks*, and caffeinated beverages. **Examples include chocolate/malt drinks, canned or packaged drinks, or cola-flavoured soft drinks.*	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 15 MONTHS TO 22 MONTHS

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %

Height: _____ cm _____ %

PHYSICAL EXAMINATION

Eye Examination: Fixation on moving object: Right eye ☐ Left eye ☐

Cornea/Lens ☐ Pupillary Light reflex ☐

Red Reflex ☐ Nystagmus: Yes ☐ No ☐

Squint: Yes ☐ No ☐

Roving eye movement: Yes ☐ No ☐

Eye movements _____

☐ **Fontanelles** ☐ **Heart** ☐ **Femoral pulses** ☐ **Posture**

☐ **Ears** ☐ **Lungs** ☐ **Genitals** ☐ **Muscle tone**

☐ **Teeth** ☐ **Abdomen** ☐ **Spine** ☐ **Skin**

☐ **Gait**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 24 MONTHS TO 36 MONTHS

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL CONCERNS
Please inform your doctor if your child has ANY of these difficulties:
- Does not use spontaneous (non-echoed/non-imitated) 2-word phrases by 24 months
- Has lost any language or social skill
- Does not point to show things he is interested in
- Does not follow when someone is pointing something out to him
- Does not respond readily to affection
- Prefers to play alone

Please answer the following and tick "NO" / "YES"
ALL FIELDS SHOULD BE COMPLETED

Have you any worries about your child's:	NO	YES	
• Health and growth	☐	☐	Specify: _____
• Diet and feeding	☐	☐	Specify: _____
• Sleep	☐	☐	Specify: _____
• Learning	☐	☐	Specify: _____
• Behaviour	☐	☐	Specify: _____

VISION
Does your child frown, tilt his head in order to see better or close one eye while looking into the distance in bright light? ☐ ☐

HEARING
Does your child respond to sounds even when the source is not within his sight, e.g. calling of his name, ringing of the telephone? ☐ ☐

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 Your child can use a spoon to feed himself. He gets most of the food into his mouth, spilling little (Uses spoon)	☐	☐	**22**
2 Your child can completely remove any of his own clothing such as his shirt, shoes or pants. (Removes garment)	☐	☐	**24**
3 Your child plays imaginatively, like playing with a doll and pretending to comb the doll's hair. (Combs doll's hair)	☐	☐	**24.5**
4 Your child can put on any of his own clothing like underpants, socks or shoes. (Puts on clothing)	☐	☐	**34**
5 Your child uses a friend's name when referring or speaking to a friend. (Names friend)	☐	☐	**45.5**

SCREENING AT 24 MONTHS TO 36 MONTHS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	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 size. (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 card Ask the child to point to the longer line. (Picks longer line)	☐	☐	**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 cards (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 or 4 pictures correctly. (Points to pictures [2,4])	☐	☐	**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 or 4 pictures correctly. (Names pictures [2,4])	☐	☐	**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 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**

SCREENING AT 24 MONTHS TO 36 MONTHS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
15 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**
16 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**
17 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**
18 Your child can balance on each foot without any support for at least 1 second. (Balances each foot – 1 sec)	☐	☐	**37**
19 Your child can pedal a tricycle. (Pedals tricycle)	☐	☐	**41.5**

Comments of Doctor/Nurse on Developmental Checklist completed by parents:

SCREENING AT 24 MONTHS TO 36 MONTHS

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use			
1	Your child's total screen use outside of school is less than one hour daily.	☐	☐
2	Your child only watches age-appropriate content.	☐	☐
3	An adult discusses with your child about what he or she is watching*. **For example, the adult can ask the child: "what do you think will happen next?" or "why do you think the character did that?".*	☐	☐
4	Your child has screen-free mealtimes.	☐	☐
5	You avoid giving your child any screen time one hour before bed.	☐	☐
6	You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep			
7	Your child has regular sleep and wake times and gets about 11-14 hours of sleep daily (including nap time).	☐	☐
Physical Activity			
8	Your child spends at least 180 minutes doing a variety of physical activities of any intensity spread throughout the day, including crawling, walking and running.	☐	☐

SCREENING AT 24 MONTHS TO 36 MONTHS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
9	Your child engages in outdoor active play* daily. **For example, playing at outdoor playgrounds, playing catching/tag, ball games, and cycling in outdoor areas.*	☐	☐
Nutrition			
10	Your child has a structured routine* for meal and snack times daily. **This includes serving your child with meals at regular timings every day.*	☐	☐
11	Your child is given an appropriate portion* of meal and snacks^ daily. **A quarter plate of wholegrains, a quarter plate of meat and other produce, and half a plate of fruits and vegetables.* *^Offer snacks in moderation. Recommended options include wholegrain foods, fruits and vegetables (e.g., wholegrain biscuits, carrot sticks).*	☐	☐
12	You avoid giving your child any fruit juices, sugar- and artificially sweetened drinks*, and caffeinated beverages. **Examples include chocolate/malt drinks, canned or packaged drinks, or cola-flavoured soft drinks.*	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents1	https://go.gov.sg/cds-parents2	https://go.gov.sg/cds-parents3	https://go.gov.sg/cds-parents4

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 24 MONTHS TO 36 MONTHS

GROWTH

Weight: _____ kg _____ % Occipito-Frontal Circumference: _____ cm _____ %

Height: _____ cm _____ % BMI: _____ %

PHYSICAL EXAMINATION

Eye Examination:

Squint: Yes ☐ No ☐

Objection to occlusion in one eye: Yes ☐ No ☐

Nystagmus: Yes ☐ No ☐

Roving eye movement: Yes ☐ No ☐

Cornea/Lens ☐ Red Reflex ☐ Pupillary Light reflex ☐

Eye movements _____

☐ **Fontanelles** ☐ **Heart** ☐ **Femoral pulses** ☐ **Spine**

☐ **Ears** ☐ **Lungs** ☐ **Genitals** ☐ **Posture**

☐ **Teeth** ☐ **Abdomen** ☐ **Limbs** ☐ **Skin**

☐ **Gait**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

SCREENING AT 4 YEARS TO 6 YEARS

Date of Screening: _____ Age: _____ Main caregiver: _____

PARENTAL/TEACHER'S CONCERNS

Please inform your doctor if your child has ANY of these difficulties:

- Does not follow when someone is pointing something out to him
- Is unable to sit through, follow instructions and take turns when playing
- Does not respond readily to affection
- Is not interested in playing with others
- Seems to be in his own world
- Becomes very upset/anxious/clingy when separating from you, e.g. when dropping him off at school or when he is going to a new place
- Has great difficulty controlling his temper or gets very moody/physically aggressive when upset
- Finds it hard to make friends

Please answer the following and tick "NO" / "YES"
ALL FIELDS SHOULD BE COMPLETED

Have you any worries about your child's:	NO	YES	
• Health and growth	☐	☐	Specify: _____
• Diet and feeding	☐	☐	Specify: _____
• Sleep	☐	☐	Specify: _____
• Learning	☐	☐	Specify: _____
• Behaviour	☐	☐	Specify: _____

VISION

Does your child frown, tilt his head in order to see better or close one eye while looking into the distance in bright light? ☐ ☐

HEARING

Does your child respond to sounds even when the source is not within his sight, e.g. calling of his name, ringing of the telephone? ☐ ☐

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	YES	NO	Age (mths) when 90% achieve the milestone
Personal Social			
1 Your child can put on any of his own clothing like underpants, socks or shoes. (Puts on clothing)	☐	☐	**34**
2 Your child uses a friend's name when referring or speaking to a friend. (Names a friend)	☐	☐	**45.5**
3 Your child can brush his teeth with some help. (Brushes teeth)	☐	☐	**51**
4 Your child can dress himself up completely and correctly without help except for tying shoe laces, buttoning or zipping the back of dresses. (Dresses, with no help)	☐	☐	**54**
5 Your child can brush all his teeth alone, including placing the toothpaste on the toothbrush. He is able to do this without help or supervision. (Brushes teeth, with no help)	☐	☐	**69**

SCREENING AT 4 YEARS TO 6 YEARS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED	YES	NO	Age (mths) when 90% achieve the milestone
Fine Motor Adaptive			
6 When shown a picture card of a circle, your child can draw a figure approximating a circle that is closed or very nearly closed. (Copies a circle)	☐	☐	**47**
7 When shown a picture of a cross, your child can draw two lines, not necessarily straight exactly, which intersect at any point. (Copies a cross)	☐	☐	**50**
8 When shown a picture card of a square, your child can draw a figure with straight lines and with 4 square corners. (Copies a square)	☐	☐	**56**
9 When asked to draw a picture of a boy or a girl, your child can draw at least 3 or 6 parts. (Draws person [3,6 parts])	☐	☐	**57.5** **62.5**
Language			
10 Show your child 5 black and white drawn picture cards (size 6 by 8 cm) of a dog, bird, fish, bus and baby. When asked to name each picture, one at a time, he can name 2 pictures or 4 pictures correctly. (Names pictures [2,4])	☐	☐	**30** **37**
11 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**
12 Your child is able to make a complete sentence that includes any of these words – and, or, then but, because, so. (The sentence can be Singlish and incorrect tenses can be ignored)	☐	☐	**48**
13 Your child can count from 1 to 10 in correct sequence. (Rote counts to 10)	☐	☐	**52**
14 When asked on the functions of these 3 objects (cup, pencil, chair), i.e. "What is a cup used for?" your child can give the correct answer to all 3 questions. (Knows functions of objects [cup, pencil, chair])	☐	☐	**55.5**
15 When shown coloured blocks in red, blue, green and yellow one at a time, he can name at least 3 colours correctly. (Names 3 colours)	☐	☐	**63.5**
16 Put 8 blocks in front of your child and a piece of paper next to the blocks. Tell your child to "put one block on the paper". After he has done so, remove the block from the paper and place it back with the other blocks. Repeat the procedure requesting 3 then 5 blocks. Repeat the order of blocks (3,1,5). (Places and counts)	☐	☐	**64**

SCREENING AT 4 YEARS TO 6 YEARS

DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes"/"No" ALL FIELDS SHOULD BE COMPLETED**	**YES**	**NO**	**Age (mths) when 90% achieve the milestone**
Gross Motor			
17 Your child can pedal a tricycle. (Pedals tricycle)	☐	☐	**41.5**
18 Your child can walk up and down steps with alternating feet without the use of the railing. (Walks up and down the stairs)	☐	☐	**43-44**
19 Your child can balance on one foot (either foot) unsupported for at least 2 seconds. (Balances each foot – 2 seconds)	☐	☐	**46-47**
20 Your child can hop at least 2 times in a row, on one foot without any support. (Hops)	☐	☐	**53.5**
21 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 by parents:

SCREENING AT 4 YEARS TO 6 YEARS

Date of Completion: _____ Age: _____ Main caregiver: _____

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Screen Use			
1	Your child's total screen use outside of school is less than one hour daily.	☐	☐
2	Your child only watches age-appropriate content.	☐	☐
3	An adult discusses with your child about what he or she is watching*. **For example, the adult can ask the child: "what do you think will happen next?" or "why do you think the character did that?".*	☐	☐
4	Your child has screen-free mealtimes.	☐	☐
5	You avoid giving your child any screen time one hour before bed.	☐	☐
6	You avoid exposing your child to any background screen use*. **Refers to television or devices displaying content in the background, which causes distractions, even when your child is not watching them.*	☐	☐
Sleep			
7	Your child gets about 10-13 hours of sleep daily at 4 to 5 years old, and 9-13 hours of sleep daily at 5 to 6 years old (including nap time, if any).	☐	☐

SCREENING AT 4 YEARS TO 6 YEARS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
Physical Activity			
8	Your child spends at least 180 minutes doing a variety of physical activities* of any intensity spread throughout the day. **These can come from many common activities such as playground play, ball games and cycling which involve movements like running, jumping, catching, throwing and kicking.*	☐	☐
9	Of the time spent on physical activities, your child spends at least 60 minutes on moderate to vigorous-intensity activities* spread throughout the day. **For example, running, rope-skipping and games at the playground such as tag/catching.*	☐	☐
10	Your child engages in outdoor active play* daily. **For example, playing at outdoor playgrounds, playing catching/tag, ball games, and cycling in outdoor areas.*		
Nutrition			
11	Your child has a structured routine* for meal and snack times daily. **This includes serving your child with meals at regular timings every day.*	☐	☐
12	Your child is given an appropriate portion* of meal and snacks^ daily. **A quarter plate of wholegrains, a quarter plate of meat and other produce, and half a plate of fruits and vegetables.* *^Offer snacks in moderation. Recommended options include wholegrain foods, fruits and vegetables (e.g., wholegrain biscuits, carrot sticks).*	☐	☐

SCREENING AT 4 YEARS TO 6 YEARS

CHILDHOOD HEALTH BEHAVIOURS CHECKLIST (TO BE COMPLETED BY PARENTS) **Please tick "Yes/Most of the time" or "No/Rarely"** **ALL FIELDS SHOULD BE COMPLETED**		**YES/ MOST OF THE TIME**	**NO/ RARELY**
13	Your child only consumes water, or occasionally, beverages that are graded Nutri-Grade A or B* and/or labelled with the Healthier Choice Symbol^. These beverages include chocolate/malt drinks, and fruit juices. **Beverages graded Nutri-Grade A or B*  *^Healthier Choice Symbol* 	☐	☐
14	You avoid giving your child any caffeinated beverages such as energy drinks, cola-flavoured soft drinks and bubble teas containing caffeine.	☐	☐

IF YOUR ANSWER IS "NO/RARELY" FOR ANY OF THE QUESTIONS, OR IF YOU NEED MORE INFORMATION, REFER TO THE FOLLOWING RESOURCES:

Screen Use	Sleep	Physical Activity	Nutrition
https://go.gov.sg/cds-parents5	https://go.gov.sg/cds-parents6	https://go.gov.sg/cds-parents7	https://go.gov.sg/cds-parents8

Comments of Doctor/Nurse on Childhood Health Behaviours Checklist completed by parents:

SCREENING AT 4 YEARS TO 6 YEARS

GROWTH

Weight: _____ kg _____ % BMI: _____ %

Height: _____ cm _____ %

PHYSICAL EXAMINATION

Eye Examination:

Squint: Yes ☐ No ☐

Nystagmus: Yes ☐ No ☐

Roving 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 other visual findings: _____

☐ **Ears**	☐ **Heart**	☐ **Femoral pulses**	☐ **Spine**
☐ **Teeth**	☐ **Lungs**	☐ **Genitals**	☐ **Posture**
☐ **Skin**	☐ **Abdomen**	☐ **Limbs**	☐ **Gait**

OUTCOME OF EXAMINATION

☐ **Normal** Next routine check at: _____

☐ **Needs Follow Up At The Clinic** Review: _____

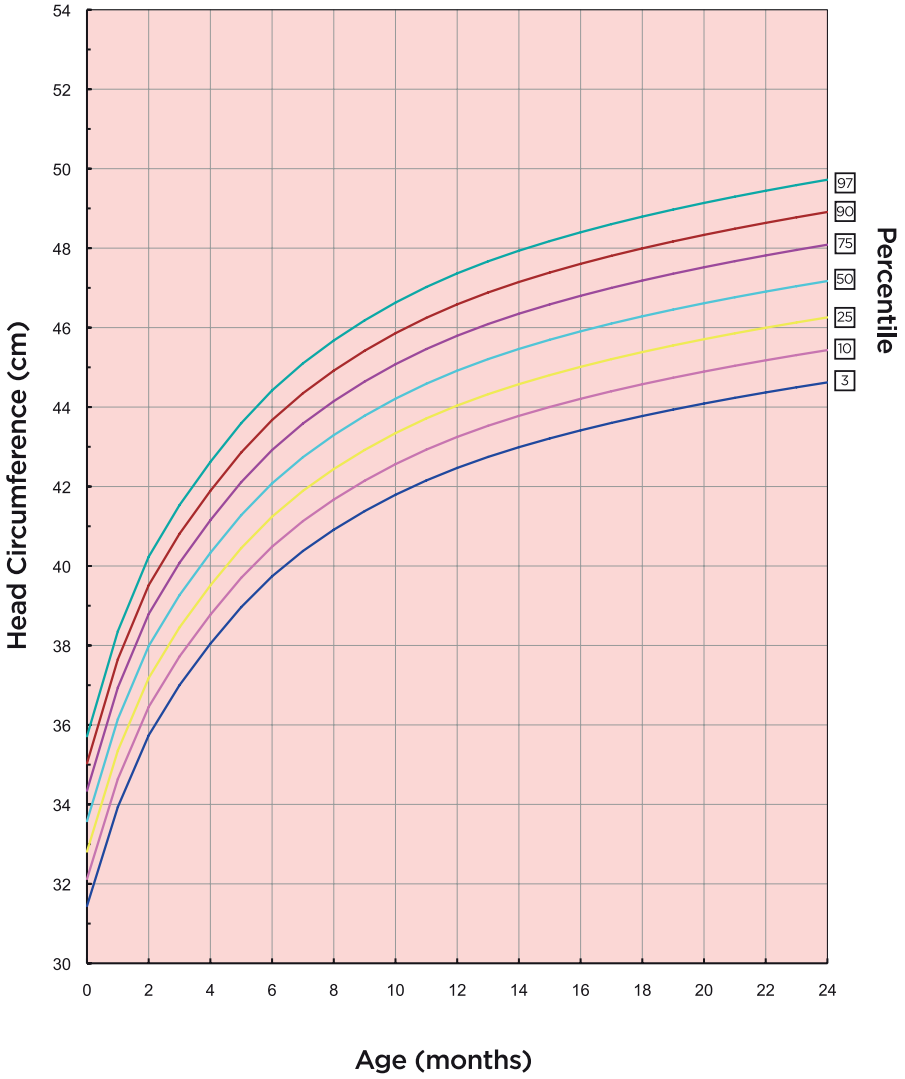
☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

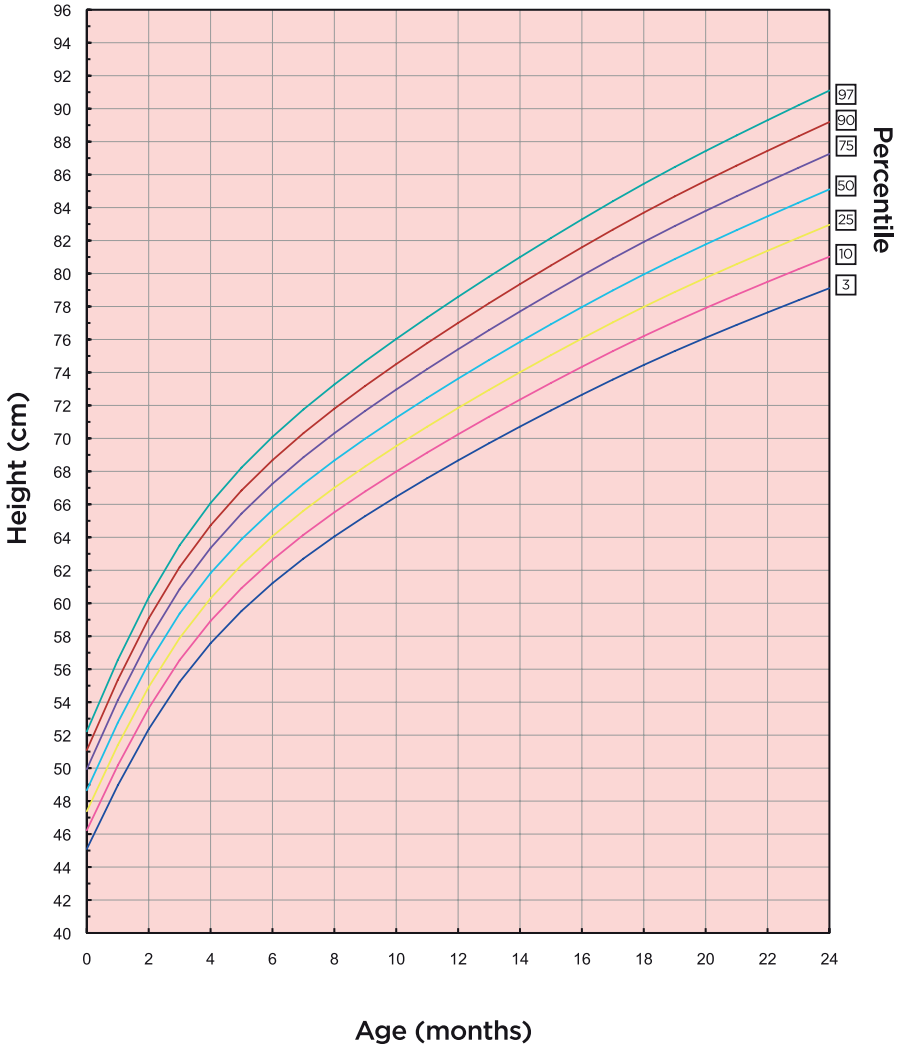
Clinic: _____ Date: _____

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



Anthropometric Study on Pre-School Children in Singapore, 2000
National Healthcare Group Polyclinics

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



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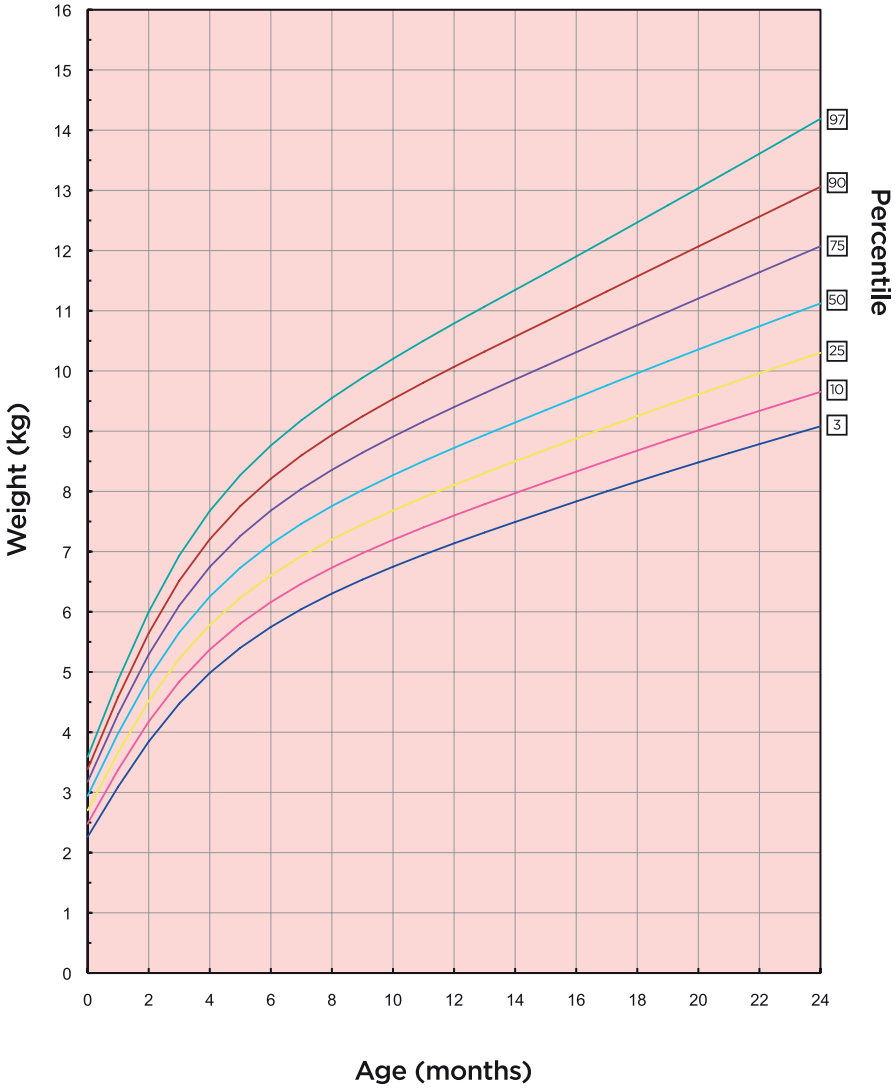

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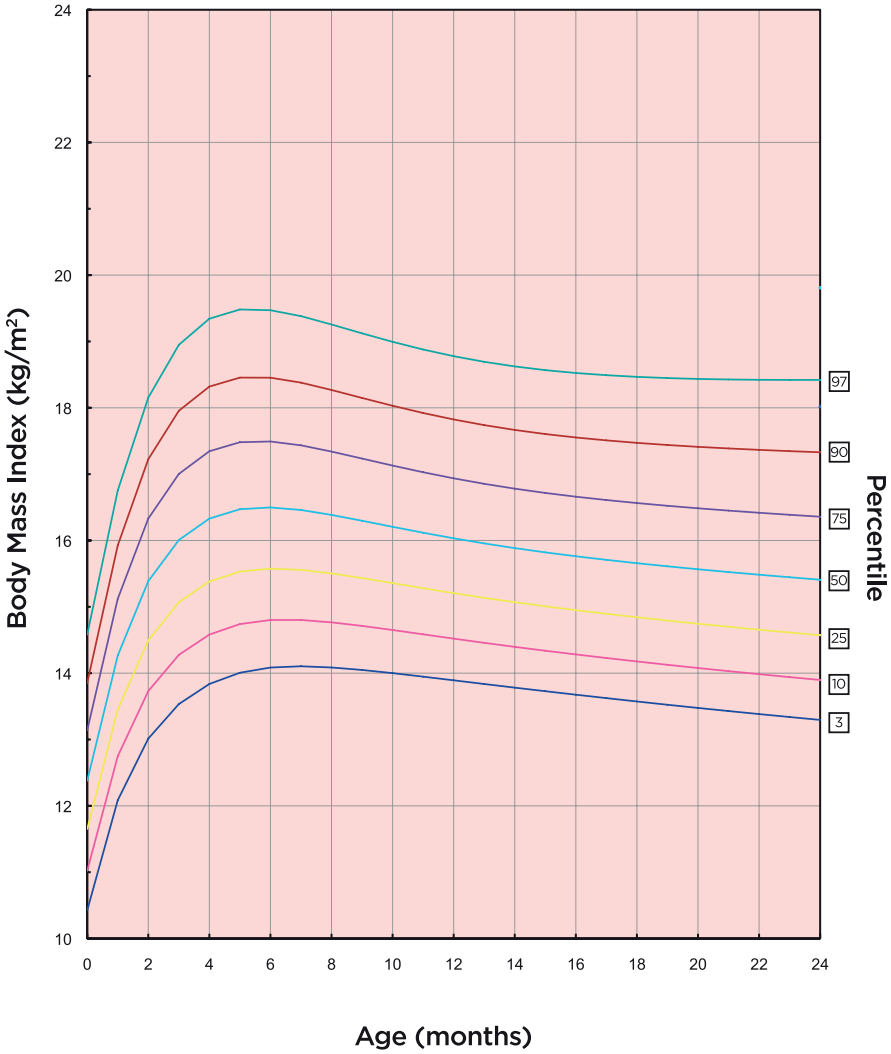
PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 0 TO 24 MONTHS



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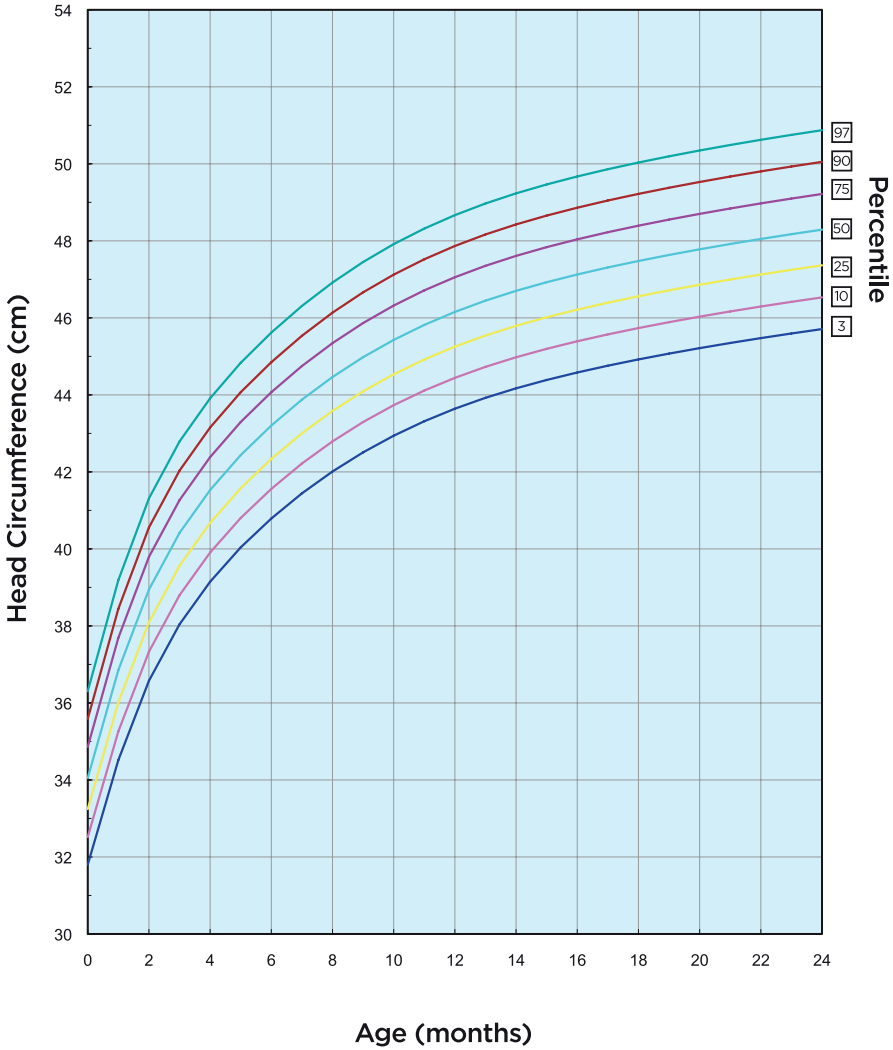
PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE BOYS AGED 0 TO 24 MONTHS



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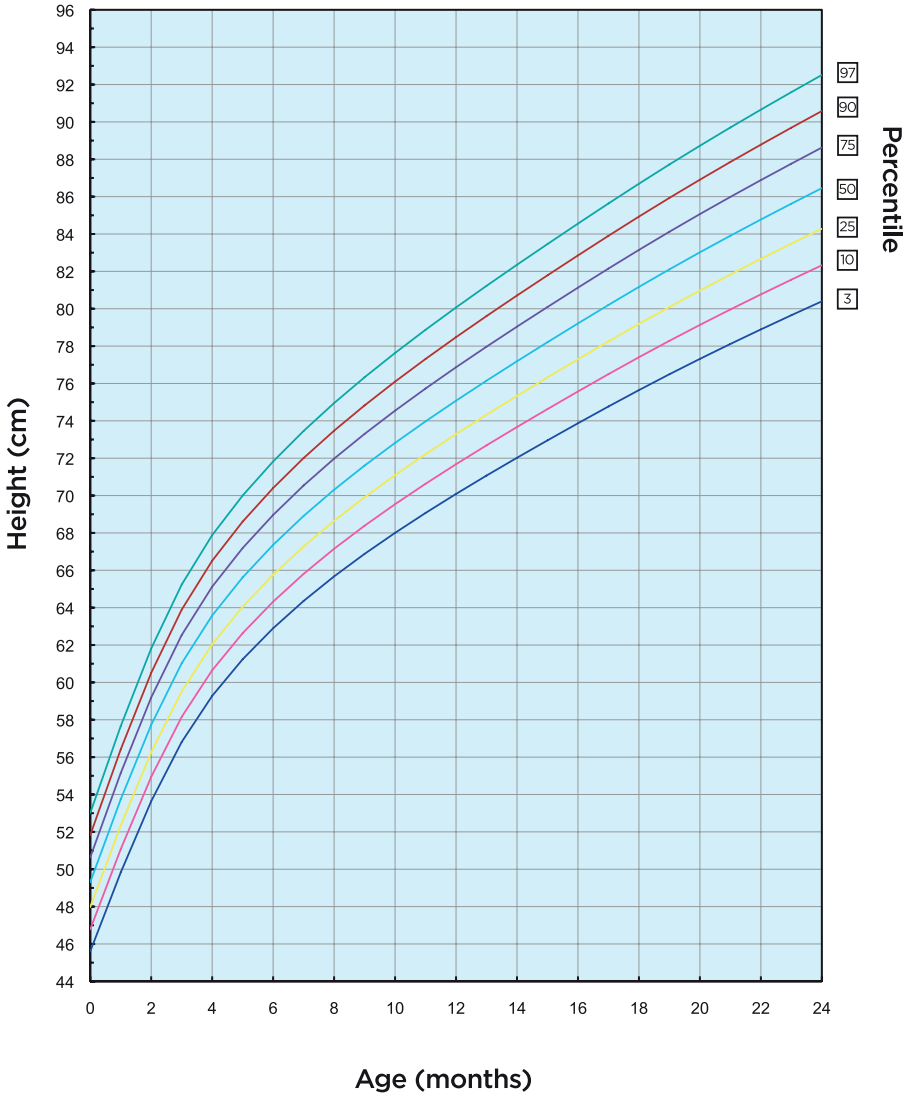
PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS



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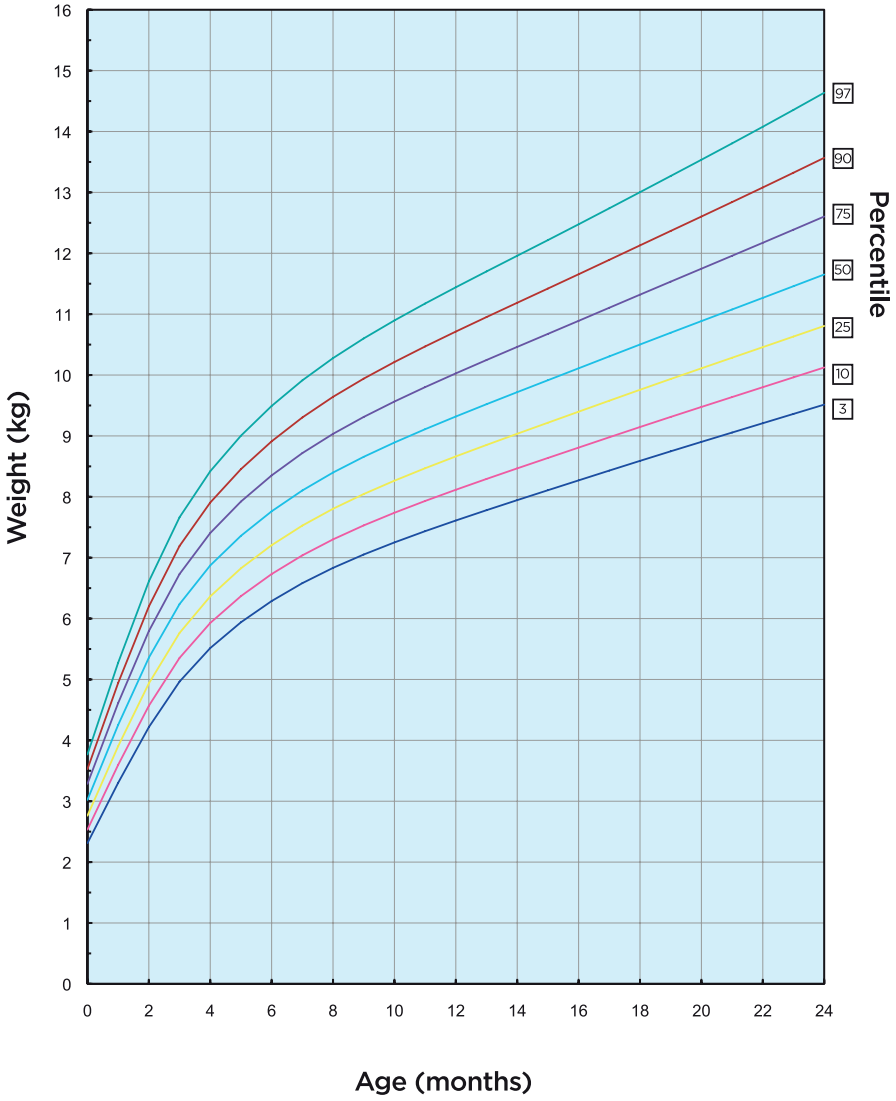
PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS



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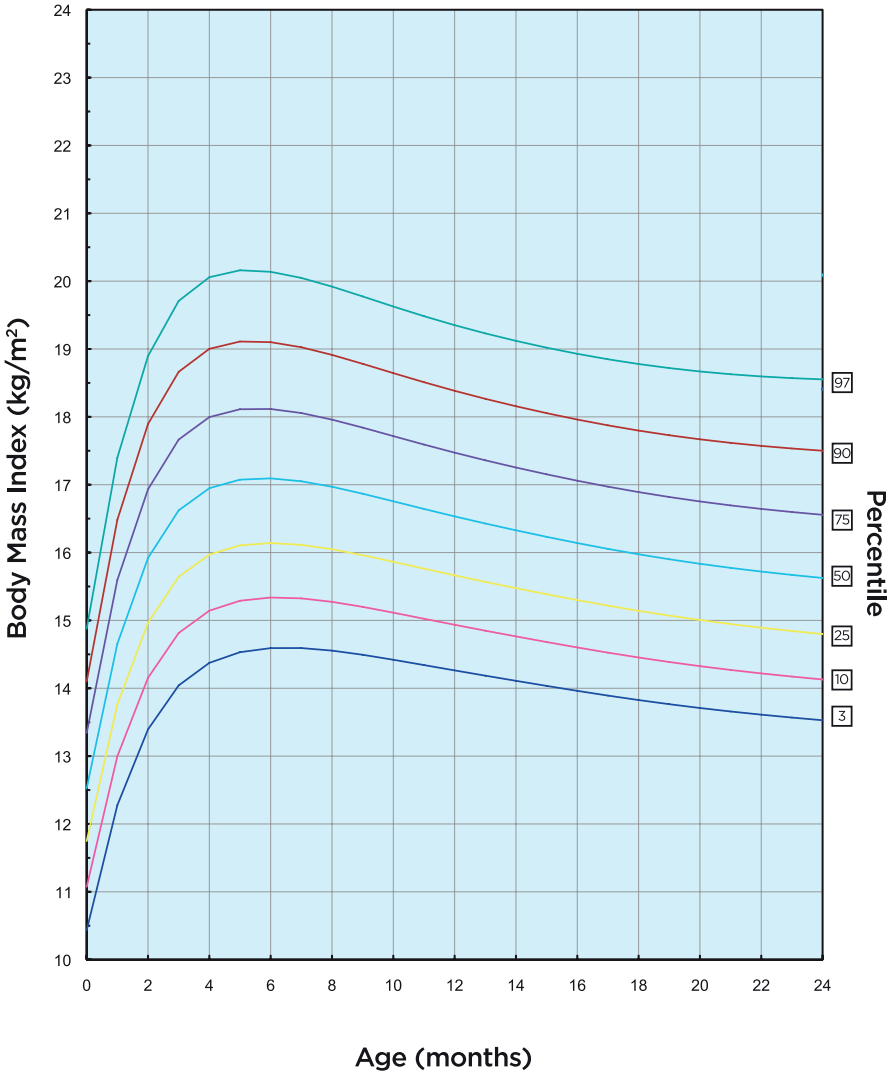
PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 0 TO 24 MONTHS



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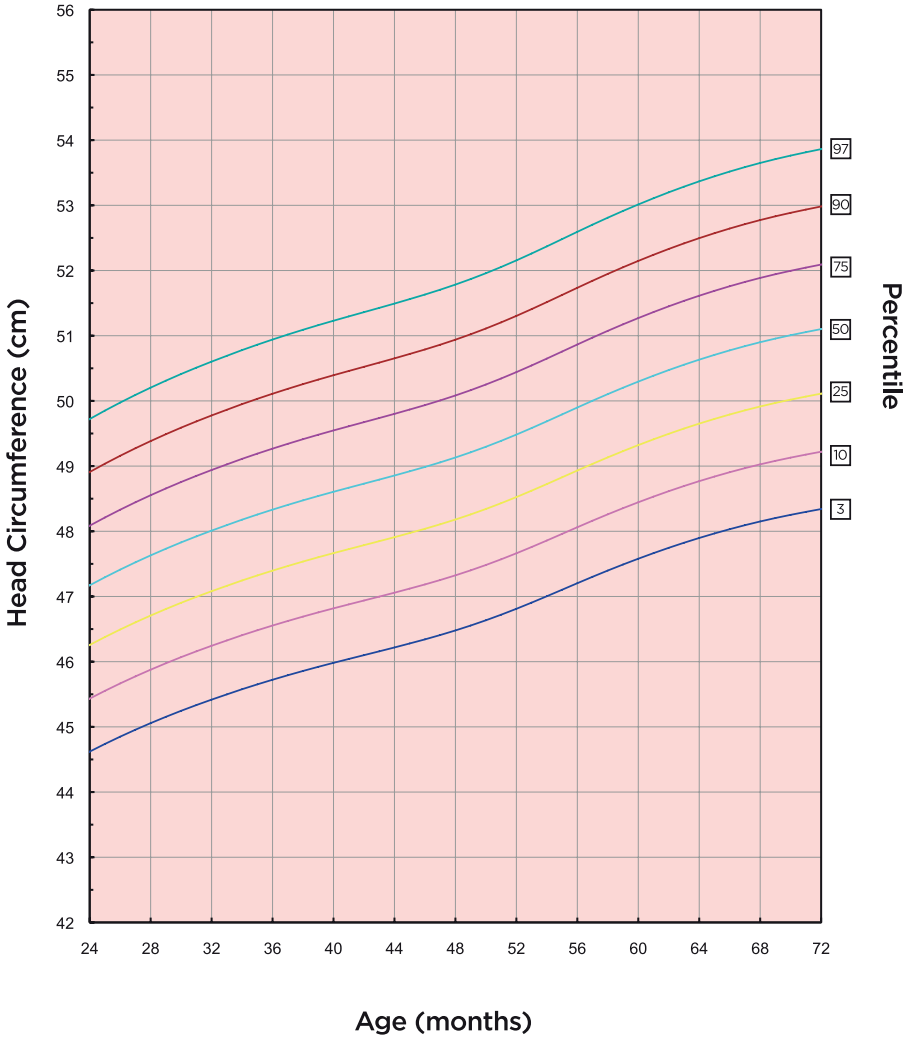
PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



Anthropometric Study on Pre-School Children in Singapore, 2000
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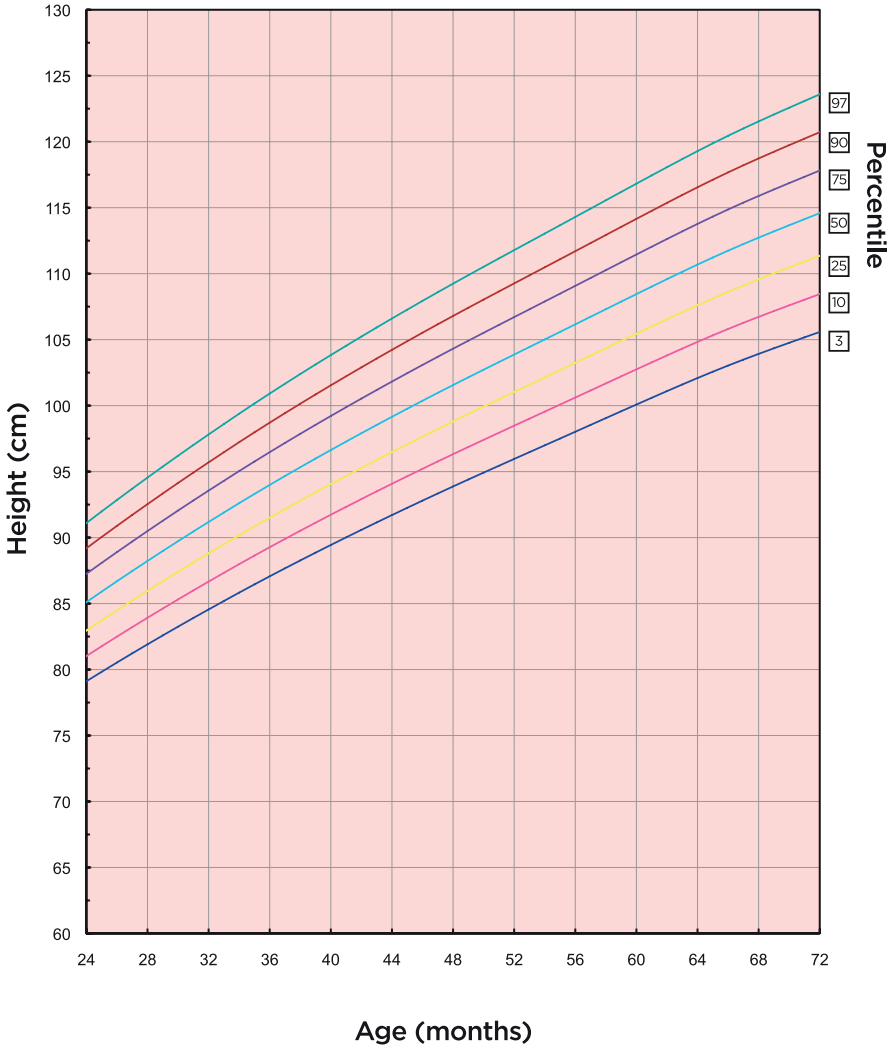
PERCENTILES OF HEIGHT-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



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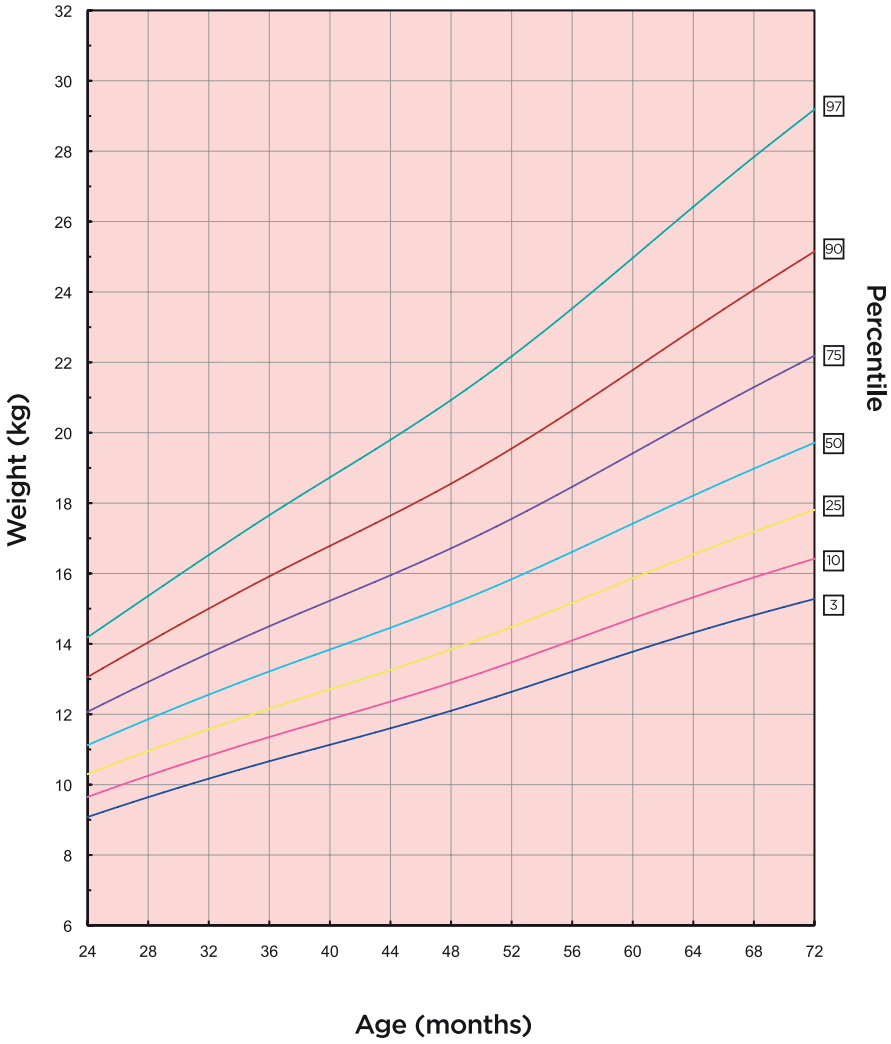
PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 24 TO 72 MONTHS



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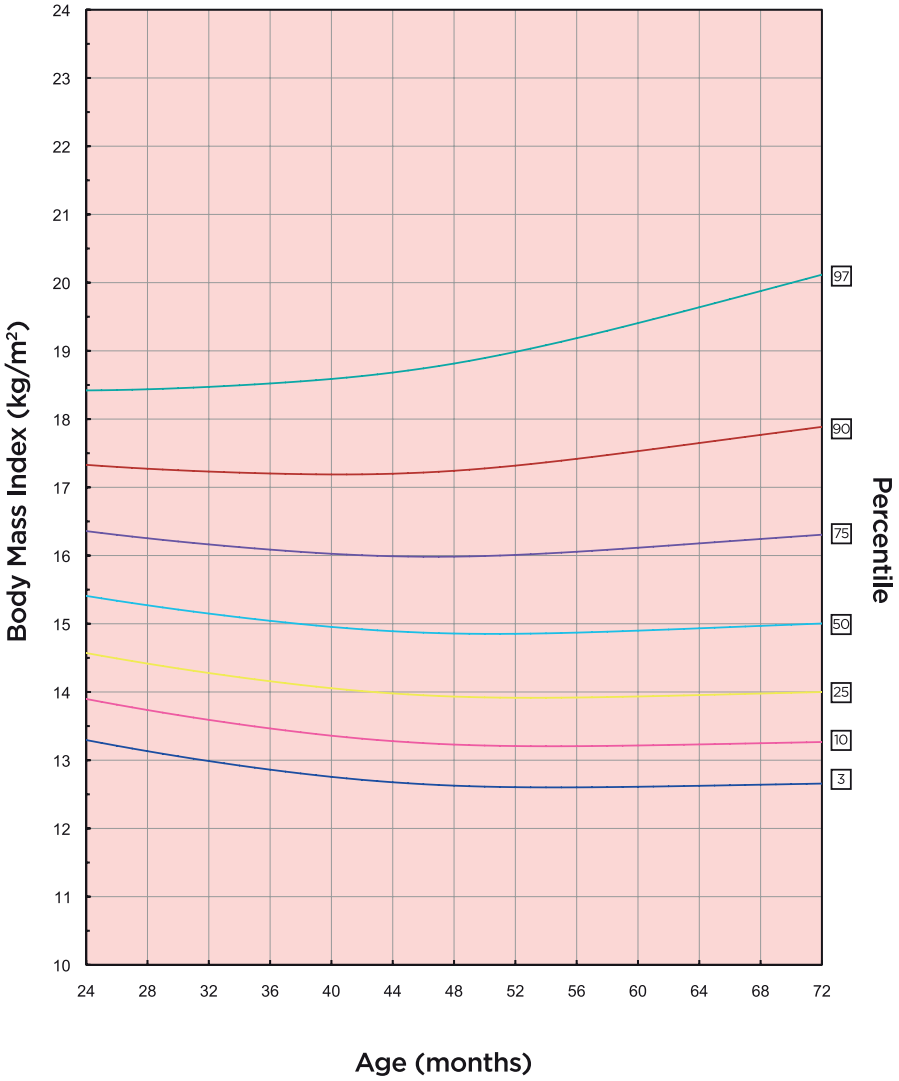

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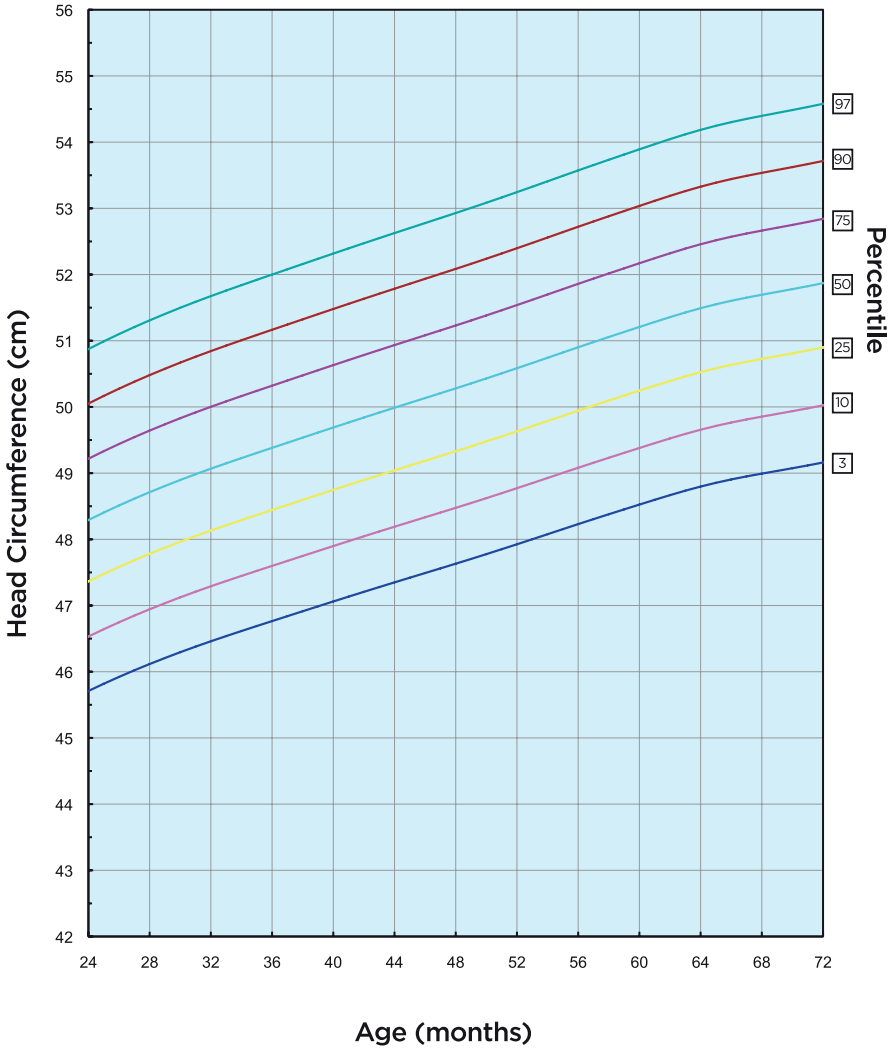

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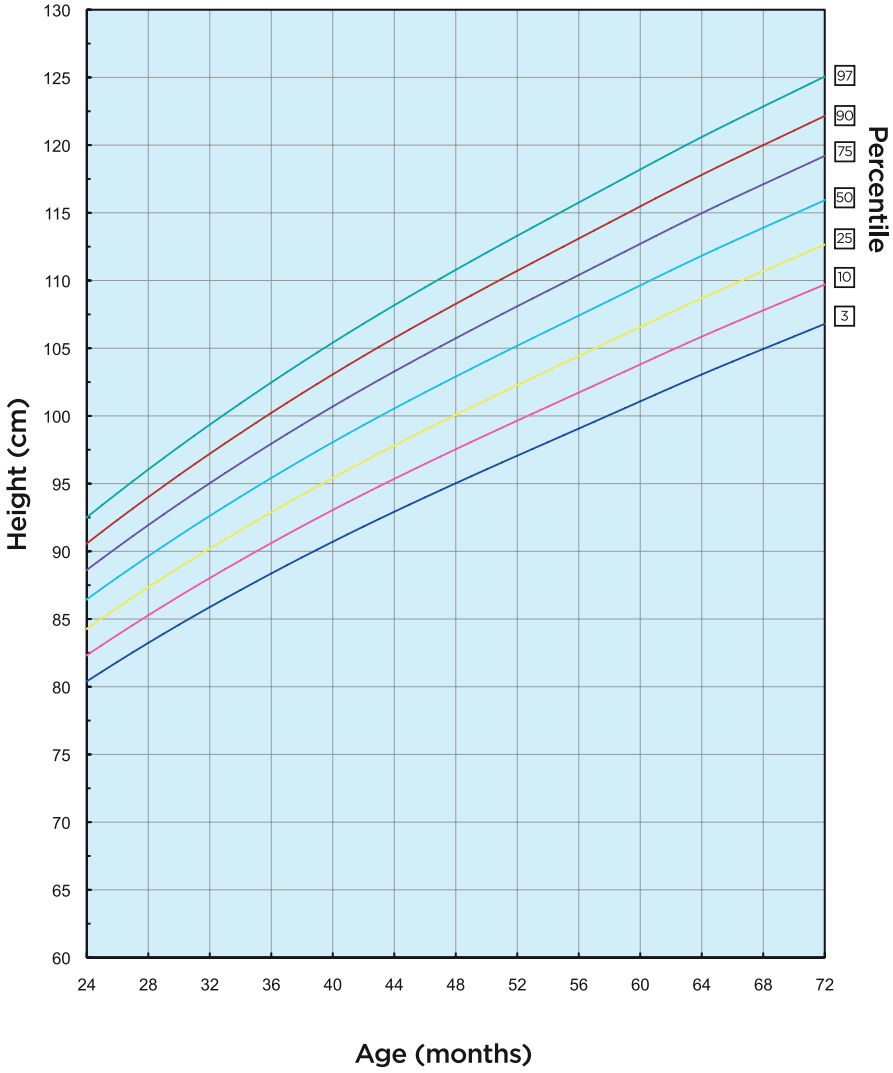

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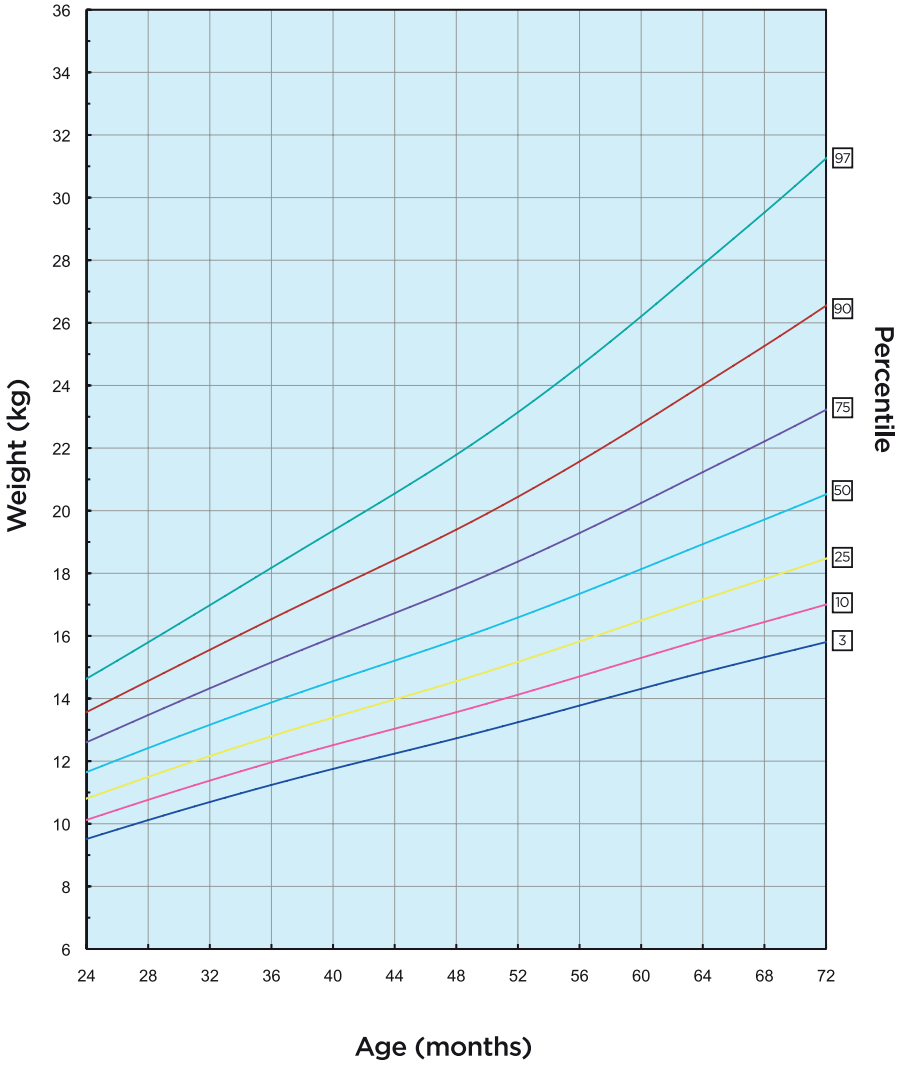

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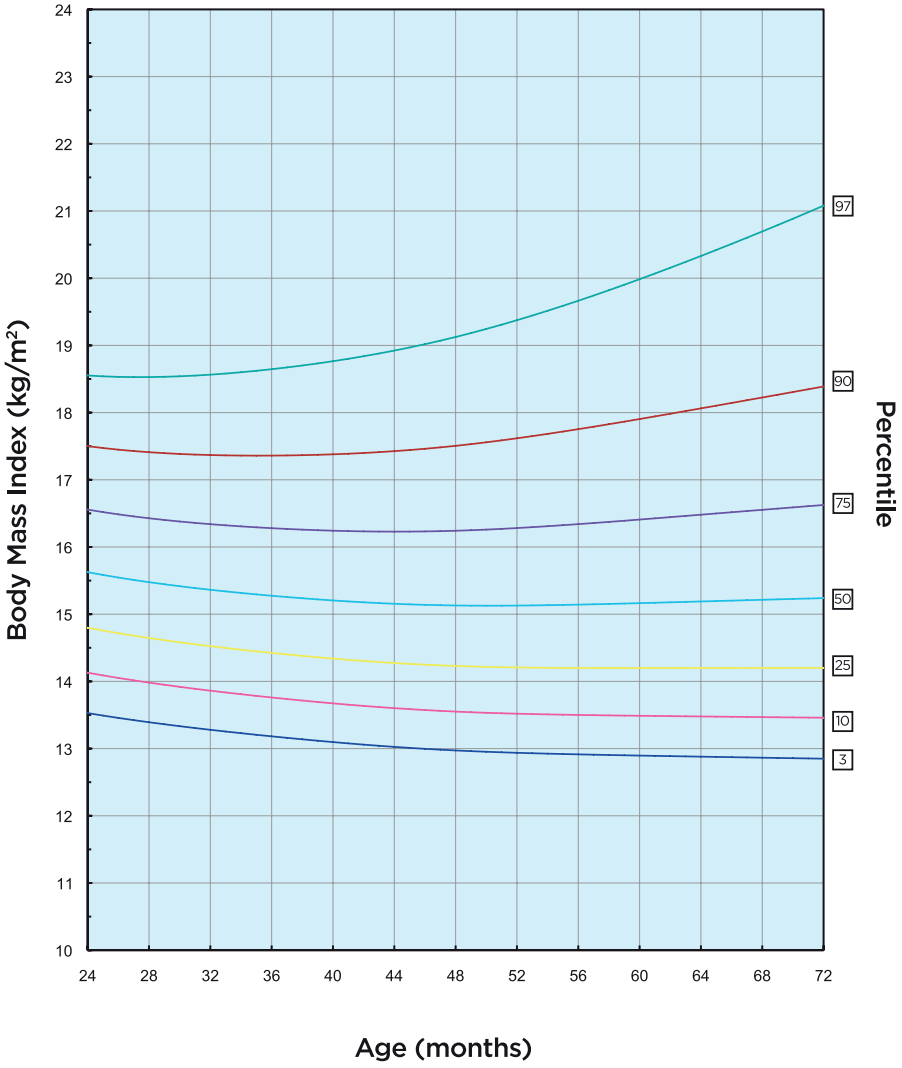

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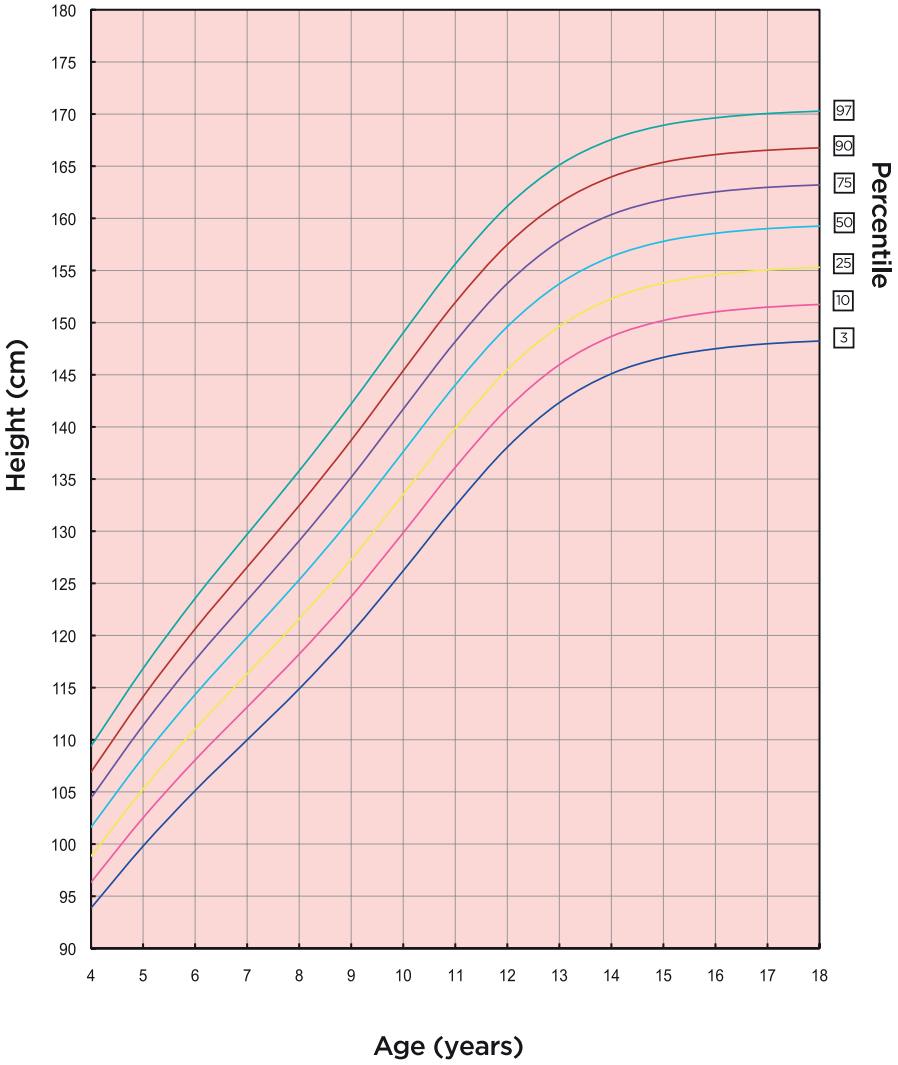
National Healthcare Group Polyclinics

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



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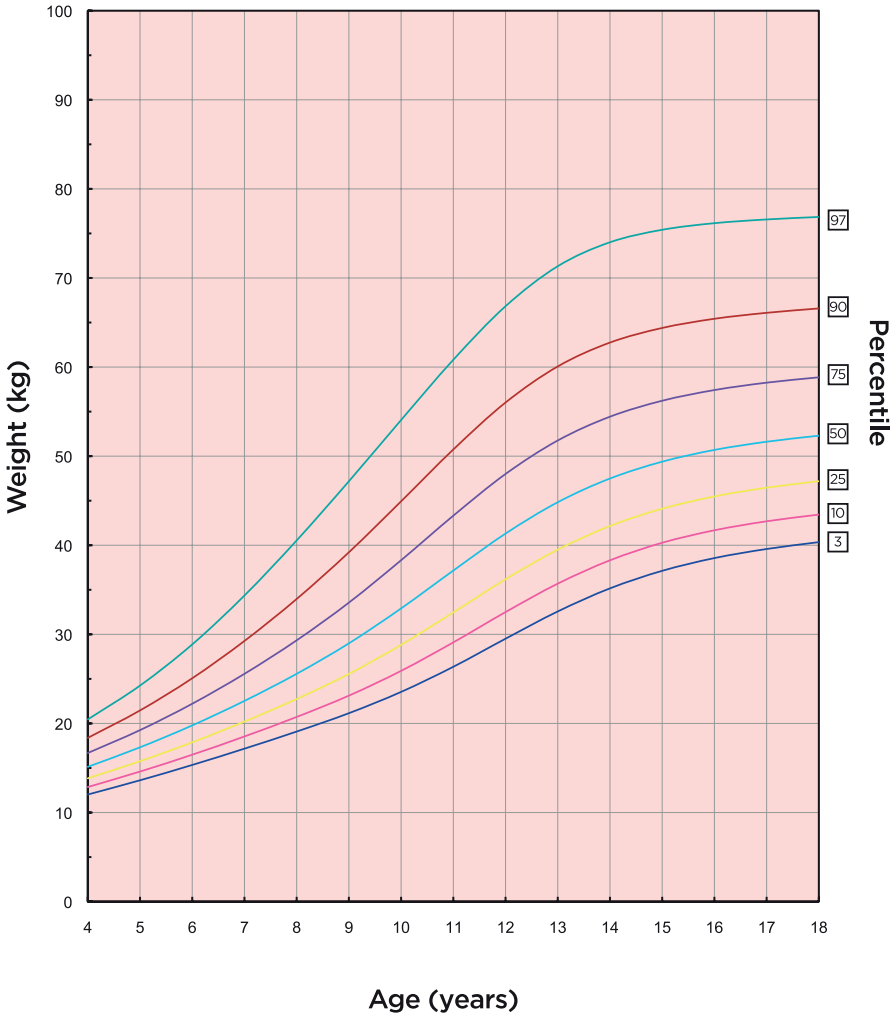
PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 4 TO 18 YEARS



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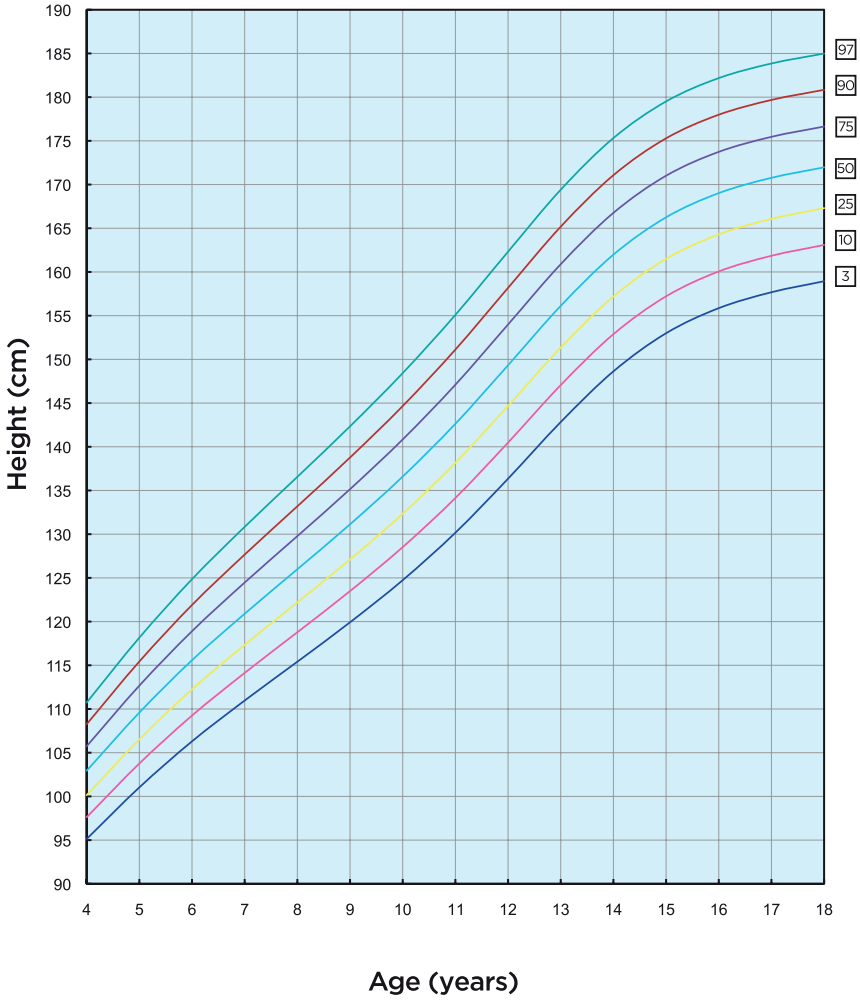

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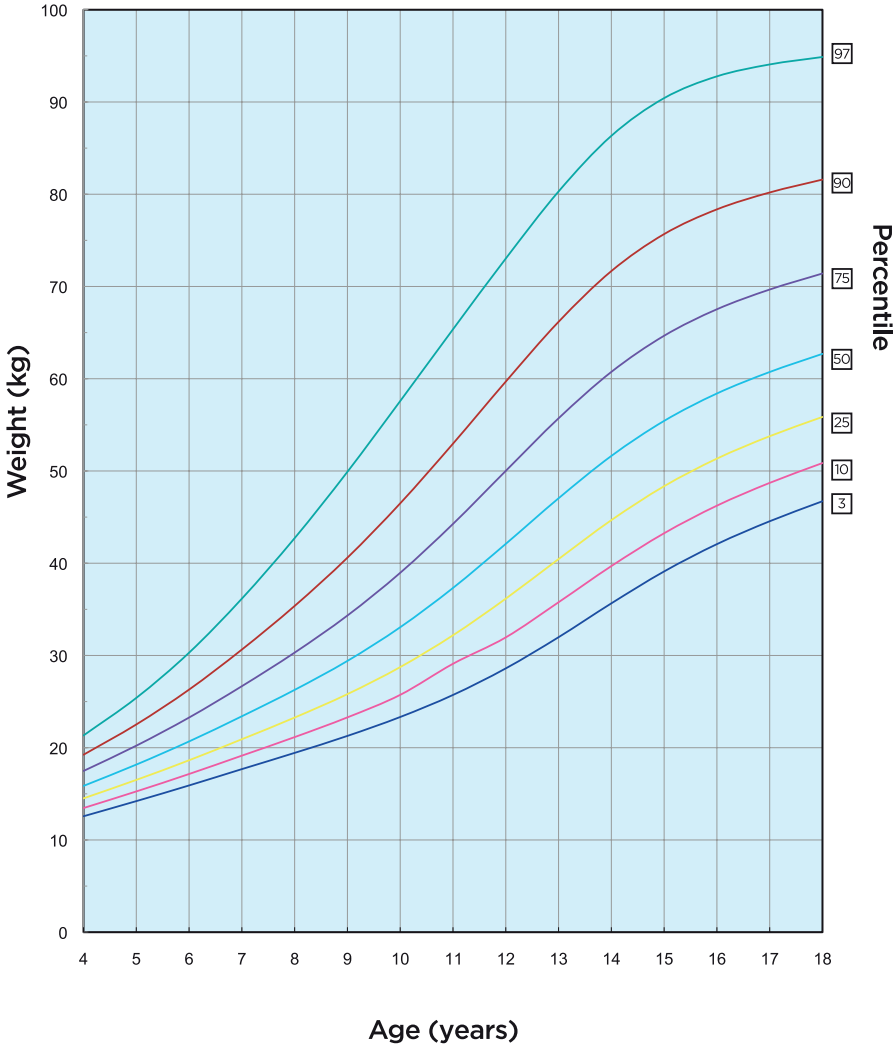
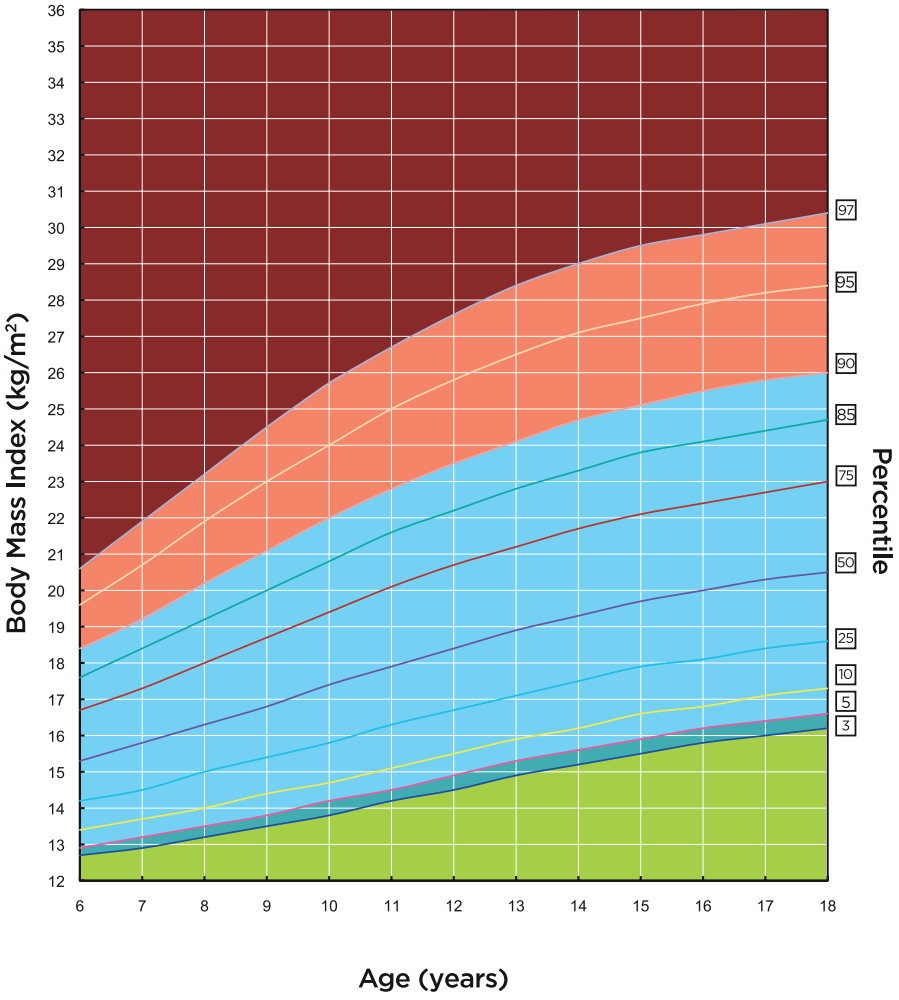


Anthropometric Study on Pre-School Children in Singapore, 2000
National Healthcare Group Polyclinics

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



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

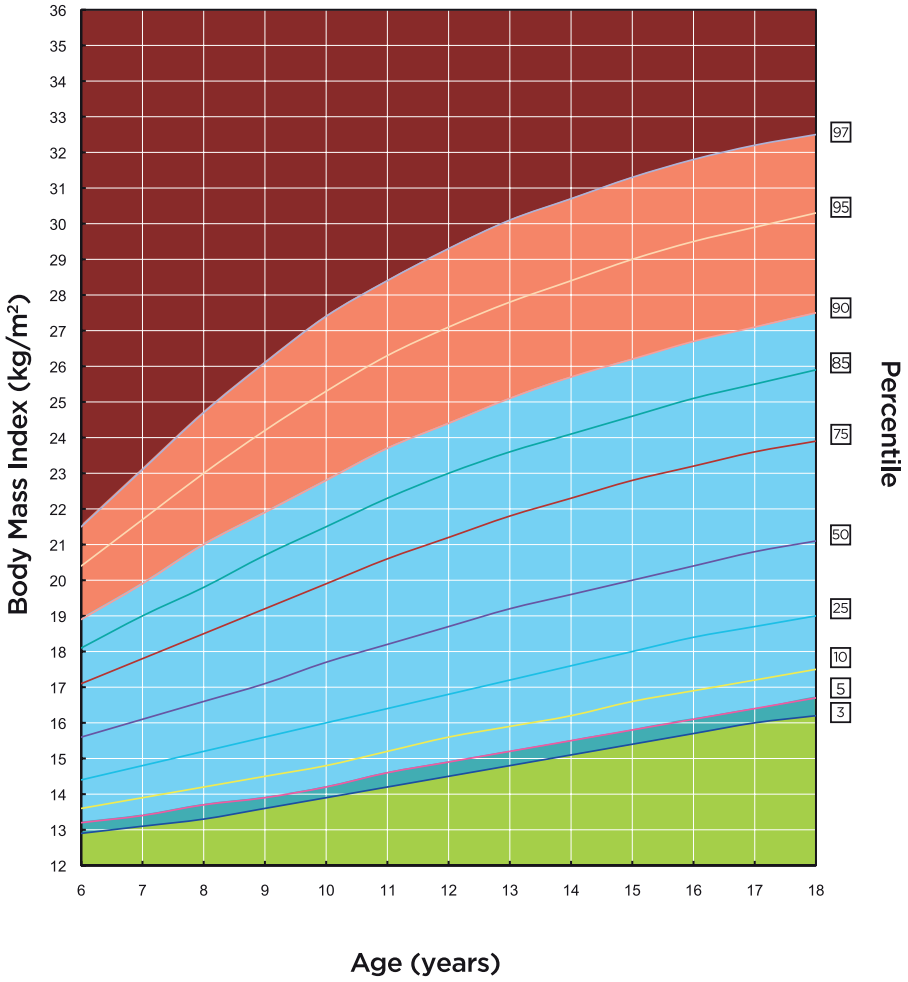
Anthropometric Study on
School Children in Singapore, 2002
Health Promotion Board

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

Weight Indicator / Age (years)	Severely Underweight	Underweight	Acceptable Weight	Overweight	Severely Overweight
	< 3rd percentile	3rd - <5th percentile	5th - <90th percentile	90th - <97th percentile	≥97th percentile
6	≤ 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
9	≤ 13.4	13.5 - 13.7	13.8 - 21.0	21.1 - 24.4	≥ 24.5
10	≤ 13.7	13.8 - 14.1	14.2 - 21.9	22.0 - 25.6	≥ 25.7
11	≤ 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
17	≤ 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

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



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

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

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

Weight Indicator / Age (years)	Severely Underweight	Underweight	Acceptable Weight	Overweight	Severely Overweight
	< 3rd percentile	3rd - <5th percentile	5th - <90th percentile	90th - <97th percentile	≥97th percentile
6	≤ 12.8	12.9 - 13.1	13.2 - 18.8	18.9 - 21.4	≥ 21.5
7	≤ 13.0	13.1 - 13.3	13.4 - 19.8	19.9 - 23.0	≥ 23.1
8	≤ 13.2	13.3 - 13.6	13.7 - 20.9	21.0 - 24.6	≥ 24.7
9	≤ 13.5	13.6 - 13.8	13.9 - 21.8	21.9 - 26.0	≥ 26.1
10	≤ 13.8	13.9 - 14.1	14.2 - 22.7	22.8 - 27.3	≥ 27.4
11	≤ 14.1	14.2 - 14.5	14.6 - 23.6	23.7 - 28.3	≥ 28.4
12	≤ 14.4	14.5 - 14.8	14.9 - 24.3	24.4 - 29.2	≥ 29.3
13	≤ 14.7	14.8 - 15.1	15.2 - 25.0	25.1 - 30.0	≥ 30.1
14	≤ 15.0	15.1 - 15.4	15.5 - 25.5	25.6 - 30.6	≥ 30.7
15	≤ 15.3	15.4 - 15.8	15.9 - 26.1	26.2 - 31.2	≥ 31.3
16	≤ 15.6	15.7 - 16.1	16.2 - 26.5	26.6 - 31.7	≥ 31.8
17	≤ 15.9	16.0 - 16.3	16.4 - 27.0	27.1 - 32.1	≥ 32.2
18	≤ 16.1	16.2 - 16.6	16.7 - 27.4	27.5 - 32.4	≥ 32.5

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

ORAL HEALTH CHECKLIST (TO BE COMPLETED BY PARENTS AT BIRTH, AGES 6 MONTHS, 1, 2 & 3 YEARS)

Tooth decay can cause a lot of pain and discomfort to your child. Good oral hygiene habits can prevent and reduce tooth decay.
Please answer the following and tick "YES" / "NO".
ALL FIELDS SHOULD BE COMPLETED.

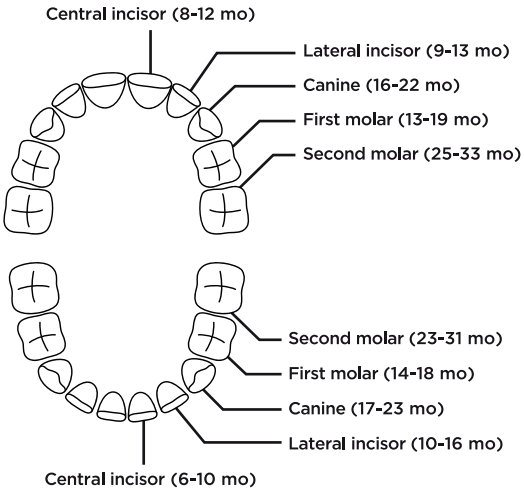
For Parents

	Yes	No
1. At Birth		
• I clean my child's gums and tongue at least twice a day with a clean, moist cloth wrapped around my index finger.	☐	☐
2. From approximately 6 months (when the first tooth emerges)		
• I brush my child's teeth at least twice a day (once in the morning and once before bed) using a soft bristled children's toothbrush.	☐	☐
• I fill my child's milk bottle with only milk/water and not any other sweetened drinks (e.g. juices, honey, or soft drinks).	☐	☐
3. From Ages 1 & 2		
• I floss and brush my child's teeth at least twice a day (once in the morning and once before bed, after last milk feed)*.	☐	☐
• I have attempted to wean my child off the milk bottle and switch to a cup.	☐	☐
• I limit the amount and frequency of sweetened beverages and foods my child consumes.	☐	☐
• I do not allow my child to fall asleep with a milk bottle containing formula milk or sugary drinks as that can cause tooth decay.	☐	☐
• When my child wakes up at night for milk, I either give water, dilute the milk in a milk bottle or try other means to soothe my child back to sleep. Frequent or prolonged exposure to sugary drinks (e.g. formula milk) will lead to dental decay.	☐	☐
• I regularly lift my child's upper lip to check for white or brown spots on his/her teeth, which may indicate dental decay.	☐	☐
• When I see possible signs of decay, I make an appointment with a dentist immediately.	☐	☐
• I have brought my child for his/her first dental check by age 1.	☐	☐
4. From Age 3		
• I floss and brush my child's teeth with a pea-sized amount of toothpaste with at least 1000ppm fluoride (F) twice a day. I ensure that my child does not swallow the toothpaste.	☐	☐
• I ensure that my child limits sugar intake.	☐	☐
• I bring my child for regular dental check-ups.	☐	☐

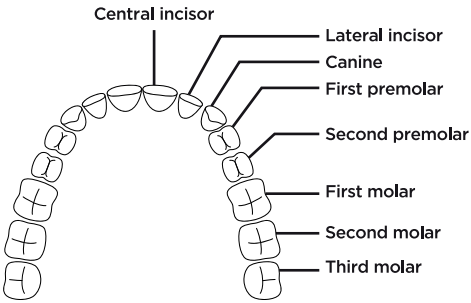
* Due to the concern for dental fluorosis, the recommendation for use of a smear amount (size of a rice grain) of 1000ppm fluoride (F) toothpaste for children < 3 years old should be limited to those at high-risk for dental caries. At the first dental visit, the dentist can determine the caries risk and make the appropriate recommendation for toothpaste use.

EXPECTED AGE OF TOOTH ERUPTION

Baby Teeth



Adult Teeth



ADULT TEETH	TOOTH	EXPECTED AGE OF TOOTH ERUPTION (years)
	Lower Central Incisor	6-7
	Upper Central Incisor	7-8
	Lower Lateral Incisor	
	Upper Lateral Incisor	8-9
	Lower Canine	9-10
	Upper Canine	11-12
	First Premolar	10-12
	Second Premolar	
	First Molar	6-7
	Second Molar	11-13
	Third Molar	17-21

CHILD SAFETY CHECKLIST
(TO BE COMPLETED BY PARENTS BEFORE DOCTOR VISIT)

	For Parents	For Clinicians
1. 4-8 weeks		
a. 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.	☐	☐
b. 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.	☐	☐
c. When preparing the water for my child's bath, I run cold water into the bathtub first followed by hot water, to prevent scalds.	☐	☐
d. I never leave my baby unattended in the bathtub.	☐	☐
e. 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.	☐	☐
f. I never leave my baby alone in the car.	☐	☐
2. 3-5 months		
a. 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.	☐	☐
b. I do not use a sarong cradle for my child. My baby sleeps in a cot which meets safety standards.	☐	☐
c. I ensure that my baby is never left alone on the bed or in a cot without the sides drawn up.	☐	☐
d. I never leave my baby unattended in the bathtub.	☐	☐
e. 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.	☐	☐
f. I never leave my baby alone in the car.	☐	☐
3. 6-12 months		
a. I ensure that small toy parts and other choking hazards (e.g. coins, pins and buttons) are kept out of my child's reach.	☐	☐
b. I never let my child use a baby walker.	☐	☐
c. I ensure that the window grilles in my home are kept locked at all times.	☐	☐
d. 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.	☐	☐
e. I keep hot drinks and foods out of my child's reach. I use table mats instead of table cloths.	☐	☐
f. I do not store pails of water in my bathroom.	☐	☐
g. 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.	☐	☐
h. I never leave my child alone in the car.	☐	☐

CHILD SAFETY CHECKLIST
(TO BE COMPLETED BY PARENTS BEFORE DOCTOR VISIT)

4. 15-22 months	For Parents	For Clinicians
a. I ensure that small toy parts and other choking hazards (e.g. coins, pins and buttons) are kept out of my child's reach.	☐	☐
b. I do not give my child foods such as whole fish balls, whole grapes etc. that may cause choking.	☐	☐
c. I have corner guards placed on tables with sharp edges.	☐	☐
d. I have covered electrical outlets that are within my child's reach and ensure that wires and cordsare secured to prevent tripping.	☐	☐
e. I keep all floors dry as wet floors may cause my child to slip and fall.	☐	☐
f. I limit my child's access to stairs by using a safety gate.	☐	☐
g. I ensure that the window grilles in my home are kept locked at all times.	☐	☐
h. I keep hot drinks and foods out of my child's reach. I use table mats instead of table cloths.	☐	☐
i. I do not allow my child to enter the kitchen.	☐	☐
j. I do not store pails of water in my bathroom.	☐	☐
k. I always supervise my child closely near water, including bathtubs, swimming pools and open bodies of water.	☐	☐
l. I ensure that my child is safely belted in an age-appropriate car seat placed in the back seat when travelling in a car.	☐	☐
m. I never leave my child alone in the car.	☐	☐

5. 24-36 months		
a. I do not give my child foods such as whole fish balls, whole grapes etc. that may cause choking.	☐	☐
b. 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)		
c. I do not allow my child to play with plastic bags to avoid suffocation.	☐	☐
d. I ensure that the window grilles in my home are kept locked at all times.	☐	☐
e. I do not allow my child to enter the kitchen.	☐	☐
f. I use non-slip mats in the bathroom.	☐	☐
g. 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 BEFORE DOCTOR VISIT)

	For Parents	For Clinicians
h. I supervise my child closely while in the playground and ensure that he/she uses only equipment that is appropriate to his/her age.	☐	☐
i. I ensure that my child is safely belted in an age-appropriate car seat placed in the back seat when travelling in a car.	☐	☐
j. I never leave my child alone in the car.	☐	☐
k. I hold on to my child or carry him/her at all times while walking along or crossing the road.	☐	☐

6. 4 to 6 years

a. I keep a close watch on my child when in the kitchen, especially when I am cooking.	☐	☐
b. 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.	☐	☐
c. I store all medicines and household chemicals in child-proof containers, keeping these as well as cleaning products out of my child's reach.	☐	☐
d. I never leave my child alone at home.	☐	☐
e. 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.	☐	☐
f. I hold on to my child at all times while walking along or crossing the road.	☐	☐
g. 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.	☐	☐
h. I supervise my child closely while in the playground, and ensure he/she uses only equipment that is appropriate to his/her age.	☐	☐
i. I ensure that my child is safely belted in an age-appropriate booster seat when travelling in a car.	☐	☐
j. 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)
- **UPAL** (Urgent pediatric advice line)
  www.kkh.com.sg/UPAL

Telephone numbers are valid at the time of revision.

National Childhood Immunisation Schedule (NCIS)

(from birth to age 17 years, effective from 1 November 2020)

Vaccine	Birth	2 months	4 months	6 months	12 months	15 months	18 months	2-4 years	5-9 years	10-11 years	12-13 years	13-14 years	15-17 years
Bacillus Calmette-Guérin (BCG)	D1												
Hepatitis B (HepB)	D1	D2		D3									
Diphtheria, tetanus and acellular pertussis (paediatric) (DTaP)		D1	D2	D3			B1						
Tetanus, reduced diphtheria and acellular pertussis (Tdap)										B2			
Inactivated poliovirus (IPV)		D1	D2	D3			B1			B2			
Haemophilus influenzae **type b (Hib)**		D1	D2	D3			B1						
Pneumococcal conjugate (PCV10 or PCV13)			D1	D2	B1								
Pneumococcal polysaccharide (PPSV23)								One or two doses for children and adolescents age **2-17 years with specific medical condition or indication.**					
Measles, mumps and rubella (MMR)					D1	D2							
Varicella (VAR)					D1	D2							
Human papillomavirus (HPV2 or HPV4)											D1 (Females)	D2 (Females)	
Influenza (INF)				Annual vaccination or per season for <u>all children</u> **age 6 months to <5 years (6-59 months).**					Annual vaccination or per season for children and adolescents age **5-17 years with specific medical condition or indication.**				

Recommended ages and doses for all children **Recommended for persons with specific medical condition or indication**

FOOTNOTES:

- **D1, D2, D3**: Dose 1, Dose 2, Dose 3
- **B1, B2**: Booster 1, Booster 2
- **10-11, 12-13, 13-14 years**: Primary 5, Secondary 1, Secondary 2 (Tdap, IPV, HPV (for females) and MMR (as catch-up) vaccines are provided as part of Health Promotion Board's school-based vaccination programme)
- **HepB**: Doses 2 and 3 are recommended to be given as part of the 6-in-1 vaccine at 2 and 6 months, respectively
- **MMR**: Only the dose 2 is recommended to be given as part of the MMRV vaccine

Immunisations for diphtheria and measles are COMPULSORY by law.

The National Immunisation Registry (NIR) maintains immunisation records for all Singapore residents age 18 years and below. Parents can view their child's immunisation records at the NIR website (https://www.nir.hpb.gov.sg/) using SingPass for authentication.

The National Childhood Immunisation Schedule has been developed by the Ministry of Health in consultation with the Expert Committee on Immunisation, which comprises specialists from disciplines including infectious diseases, microbiology, paediatrics and public health as well as representatives from both the public and private healthcare institutions.

There are other vaccines that are not part of the National Childhood Immunisation Schedule. Please make an enquiry with your family doctor, polyclinic or specialist for more information on these vaccines.

For more information and updates on immunisation, please visit https://www.nir.hpb.gov.sg/.

Immunisation Record of Vaccinations in the National Childhood Immunisation Schedule

(To be completed by the doctor/nurse giving immunisation, see footnotes below for instruction)

In addition to completing the immunisation record below, medical practitioners are requested to notify the National Immunisation Registry of vaccinations carried out. Notification of vaccination can be done via NIR Doctor Portal (https://www.nir.hpb.gov.sg/nird/ens/enslogin).

Notification of diphtheria and measles vaccinations is mandatory under the Infectious Diseases Act.

Vaccine*	Sequence	Site of Vaccination†	Brand of Vaccine§	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Bacillus Calmette-Guérin (BCG)						
Hepatitis B¶ (HepB) (e.g. Engerix-B, HBVaxPro)	Dose 1					
	Dose 2					
	Dose 3					
Diphtheria, tetanus, acellular pertussis¶ (paediatric) (DTaP)	Dose 1					
	Dose 2					
	Dose 3					
	Booster 1					
Tdap (reduced) (e.g. Adacel, Boostrix)	Booster 2					
Inactivated poliovirus¶ (IPV)	Dose 1					
	Dose 2					
	Dose 3					
	Booster 1					
	Booster 2					
Haemophilus influenzae **type b¶ (Hib)**	Dose 1					
	Dose 2					
	Dose 3					
	Booster 1					

Pneumococcal conjugate (PCV10/PCV13) Synflorix, Prevenar 13	Dose 1					
	Dose 2					
	Dose 3 (*if given*)					
	Booster 1					
Measles, mumps, rubella[1] (MMR) (e.g. M-M-R II, Priorix)	Dose 1					
	Dose 2					
Varicella (chickenpox)[1] (VAR) (e.g. Varilrix Varivax)	Dose 1					
	Dose 2					
Human papillomavirus (females) (HPV2/HPV4) (Cervarix, Gardasil)	Dose 1					
	Dose 2					
	Dose 3 (*if given*)					
Influenza (INF) (e.g. Fluarix Tetra, Influvac Tetra, SKYCellflu Quadrivalent, VaxigripTetra)						
Pneumococcal polysaccharide (PPSV23)** (e.g. Pneumovax 23)						

CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnotes:

* The trade name of commonly available vaccines is listed under the respective generic vaccine names in the "**Vaccine**" column. For combination vaccines, please refer to the Table below. The trade names are listed as examples and are non-exhaustive.

† Fill in the anatomical site of vaccine administration under the column "**Site of Vaccination**" – "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".

§ Record the generic abbreviation (e.g. HepB) or the trade name (e.g. Engerix-B, HBvaxPro) for each vaccine under the column "**Name of Vaccine**".

¶ For combination vaccines, fill in the generic abbreviation or the trade name and other details in the appropriate rows. E.g. for MMRV, fill in the abbreviation/trade name in both "MMR" and "varicella" rows. Refer to the table below for commonly available combination vaccines.

** PPSV23 is recommended only for persons with specific medical condition or indication.

TABLE: COMMONLY AVAILABLE COMBINATION VACCINES

Description	Generic Abbreviation	Trade Name
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV-Hib	Infanrix-IPV+Hib Pentaxim
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Hexaxim Infanrix hexa
Tdap and inactivated poliovirus vaccine	Tdap-IPV	Adacel-Polio Boostrix Polio
Measles, mumps, rubella and varicella vaccine	MMRV	Priorix-Tetra ProQuad

Immunisation Record of Other Vaccinations

(To be completed by the doctor/nurse giving immunisation, see footnotes below for instruction)

Vaccine*	Sequence	Site of Vaccination†	Name of Vaccine§	Date Given	Batch No.	Name of Clinic/Stamp of Clinic
Rotavirus (e.g. Rotarix, Rotateq)		Oral				
		Oral				
		Oral				
Hepatitis A[2] (e.g. Avaxim, Havrix, Vaqta)						
Meningococcal (e.g. Menactra, Menveo, Nimenrix)						
Others (Specify)						

CONTRAINDICATIONS/REACTIONS TO VACCINES:

Footnote:

* The trade name of commonly available vaccines is listed under the respective generic vaccine names in the "Vaccine" column. The trade names are listed as examples and are non-exhaustive.

† Fill in the anatomical site of vaccine administration under the column "Site of Vaccination" – "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".

§ Record the generic abbreviation (e.g. HepA) or the trade name (e.g. Avaxim, Havrix, Vaqta) for each vaccine under the column "Name of Vaccine". For combination vaccines (if any), fill in the generic abbreviation or the trade name and other details in the appropriate rows.

Summary of Clinic / Hospital Medical Records

Date	Clinic/Hospital	Diagnosis	Management	Name and Signature of Doctor

Summary of Clinic / Hospital Medical Records

Date	Clinic/Hospital	Diagnosis	Management	Name and Signature of Doctor

Summary of Clinic / Hospital Medical Records

Date	Clinic/Hospital	Diagnosis	Management	Name and Signature of Doctor

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			
	Time	Immunisation	Development Screening	Health Education

Acknowledgements

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- **Mount Elizabeth Hospital**
- **National Healthcare Group Polyclinics**
- **National University Hospital**
- **National University Polyclinics**
- **Parkway East Hospital**
- **Raffles Hospital**
- **Singapore General Hospital**
- **SingHealth Polyclinics**
- **Thomson Medical Centre**

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