
# HEALTH BOOKLET

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

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

Dear Parents/Guardians

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

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

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

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

- **Developmental Checklists** : Please complete these checklists as it will highlight any potential developmental delays your child may have. The number at the right of each developmental milestone is the age when 90% of Singapore children have achieved that particular skill. If your child is not able to achieve a certain milestone, please discuss this with your doctor.

- **Information on Allergies** : It is vital that the attending doctor completes this table if your child has any allergy, as extra precautions would need to be taken to prevent any complication.

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

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

Health Promotion Board

## 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 | | | |
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# CONTENTS

**SECTION 1**

## SECTION 2



## SECTION 3



## SECTION 4



## SECTION 5

# 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.: _____

Occupation: _____

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

***FATHER***

Name: _____ NRIC/Passport No.: _____

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 26-41
Please document additional medical findings in the summary of clinic/hospital medical record section on pages 59-63
*IEM =Inborn Errors of Metabolism, ** OAE= Oto-Acoustic Emission, and ***ABAER= Automated Brainstem Auditory Evoked Response.

# CHILD DEVELOPMENTAL SCREENING

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

Legend: * *OFC – Occipito–Frontal Circumference*
All height, weight and OFC measurements must be charted into the appropriate growth charts
*** **If the answer to any of these questions is 'No', please refer to your doctor.**

# CHILD DEVELOPMENTAL SCREENING

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

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

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

# SCREENING AT 4 WEEKS TO 8 WEEKS

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

| DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" | 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. (Head-up 45 degrees) | ☐ | ☐ | **3** |

Comments of Doctor/Nurse on Developmental 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)

☐ **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" | 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"** | **YES** | **NO** | **Age (mths) when 90% achieve the milestone** |
|---|---|---|---|
| **Gross Motor** | | | |
| 13 While your child is lying on his back, he moves his arms and legs equally. (Equal movement) | ☐ | ☐ | **1** |
| 14 When your child is placed on his stomach, he can lift his head so that the angle between his face and the surface he is lying on is approximately 45 degrees. (Head-up 45 degrees) | ☐ | ☐ | **3** |
| 15 When your child is placed on his stomach, he lifts his head and chest up so that he is looking straight ahead. (Holds head up – 90 degrees) | ☐ | ☐ | **5** |
| 16 When in a sitting position, your child can hold his head upright steadily without any bobbing motion. (Sits, head steady) | ☐ | ☐ | **5** |
| 17 When you are holding your child under his arms loosely, he is able to bear some weight on his legs for a few seconds. (Bears weight on legs) | ☐ | ☐ | **6** |

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

Comments of Doctor/Nurse on Developmental 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)

☐ **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 ☐

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 TO 12 MONTHS

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

**PARENTAL CONCERNS**
Please inform your doctor if your child
- Does not babble, point or use gestures by 12 months
- Has lost any language skills
- Does not respond readily to affection

| **DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS)** **Please tick "Yes"/"No"** | **YES** | **NO** | **Age (mths) when 90% achieve the milestone** |
|---|---|---|---|
| **Personal Social** | | | |
| 1 Your child displays excitement like kicking legs, 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 and 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 TO 12 MONTHS

| DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" | YES | NO | Age (mths) when 90% achieve the milestone |
|---|---|---|---|
| 14 Your child can pick up a small object like a raisin, using only the ends of his thumbs and index finger. (Pincer grasp) | ☐ | ☐ | **13.5** |
| **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 TO 12 MONTHS

## GROWTH

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

Length: _____ cm _____ %

## OTHER SCREENING (e.g. Hearing Screening)

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 _____

| | | | |
|---|---|---|---|
| ☐ **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 18 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"

| 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? ☐ ☐

**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" | 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 18 MONTHS

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

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

# SCREENING AT 15 MONTHS TO 18 MONTHS

## GROWTH

Weight: _____ kg _____ %  Occipito-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 2 YEARS TO 3 YEARS

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"

| 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"** | 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 2 YEARS TO 3 YEARS

| DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" | YES | NO | Age (mths) when 90% achieve the milestone |
|---|---|---|---|
| **Fine Motor Adaptive** | | | |
| 6 Your child can put 4 blocks, 6 blocks or 8 blocks, one on top of the other, without the blocks falling. This applies to small blocks of about one inch square in size. (Builds a tower of cubes [4 blocks, 6 blocks, 8 blocks]) | ☐ | ☐ | **23**<br>**29**<br>**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 and 4 pictures correctly. (Points to pictures [2,4]) | ☐ | ☐ | **25.5**<br>**28.5** |
| 11 Your child uses a combination of at least two words to make a meaningful phrase that indicates an action, like "play ball", "want drink". (Combines 2 words) | ☐ | ☐ | **27** |
| 12 Show your child 5 black and white drawn pictures cards (size 6 by 8cm) of a dog, bird, fish, bus, and baby. When asked to name each picture, one at a time, he can name 2 pictures and 4 pictures correctly. (Names pictures [2,4]) | ☐ | ☐ | **30**<br>**37** |
| 13 When asked " How old are you?", "Are you a boy or a girl?", "What is your name?", your child gives the correct answer to 2 out of 3 questions. (Knows age/sex/name) | ☐ | ☐ | **40** |
| **Gross Motor** | | | |
| 14 Your child is able to stoop or bend to pick up a toy from the floor and return to a standing position without sitting down or touching the floor with his hands. (Stoops to recover) | ☐ | ☐ | **15.5** |
| 15 Your child can walk up several steps of the staircase by himself. He may use the wall or rail for support but not hold on to a person. (Walks up steps) | ☐ | ☐ | **21.5** |

# SCREENING AT 2 YEARS TO 3 YEARS

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

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

# SCREENING AT 2 YEARS TO 3 YEARS

## 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"

| 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"** | **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, no help) | ☐ | ☐ | **69** |

# SCREENING AT 4 YEARS TO 6 YEARS

| DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" | 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**<br>**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 and 4 pictures correctly. (Names pictures [2,4]) | ☐ | ☐ | **30**<br>**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 can count from 1 to 10 in correct sequence. (Rote counts to 10) | ☐ | ☐ | **52** |
| 13 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** |
| 14 When shown coloured blocks in red, blue, green and yellow one at a time, he can name at least 3 colours correctly. (Names three colours) | ☐ | ☐ | **63.5** |
| 15 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** |
| **Gross Motor** | | | |
| 16 Your child can pedal a tricycle. (Pedals tricycle) | ☐ | ☐ | **41.5** |
| 17 Your child can hop at least 2 times in a row, on one foot without any support. (Hops) | ☐ | ☐ | **53.5** |

# SCREENING AT 4 YEARS TO 6 YEARS

| DEVELOPMENTAL CHECKLIST (TO BE COMPLETED BY PARENTS) Please tick "Yes"/"No" | YES | NO | Age (mths) when 90% achieve the milestone |
|---|---|---|---|
| 18 Your child can balance on one foot (either foot) unsupported for at least 5 seconds. (Balances each foot - 5 seconds) | ☐ | ☐ | 57 |

Comments of Doctor/Nurse on Developmental Checklist completed 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: _____

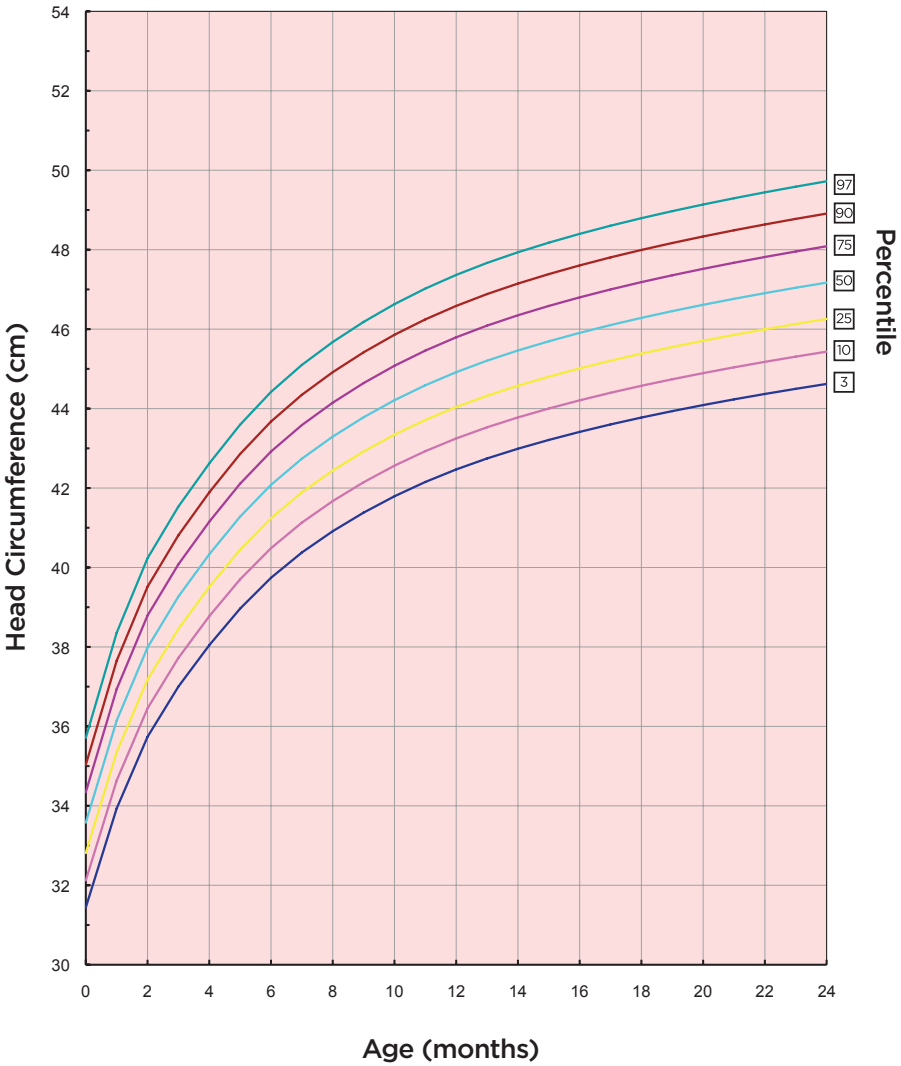
☐ **Needs Further Evaluation** Referred to: _____

Remarks (if any): _____

Doctor / Nurse: _____ Signature: _____

Clinic: _____ Date: _____

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

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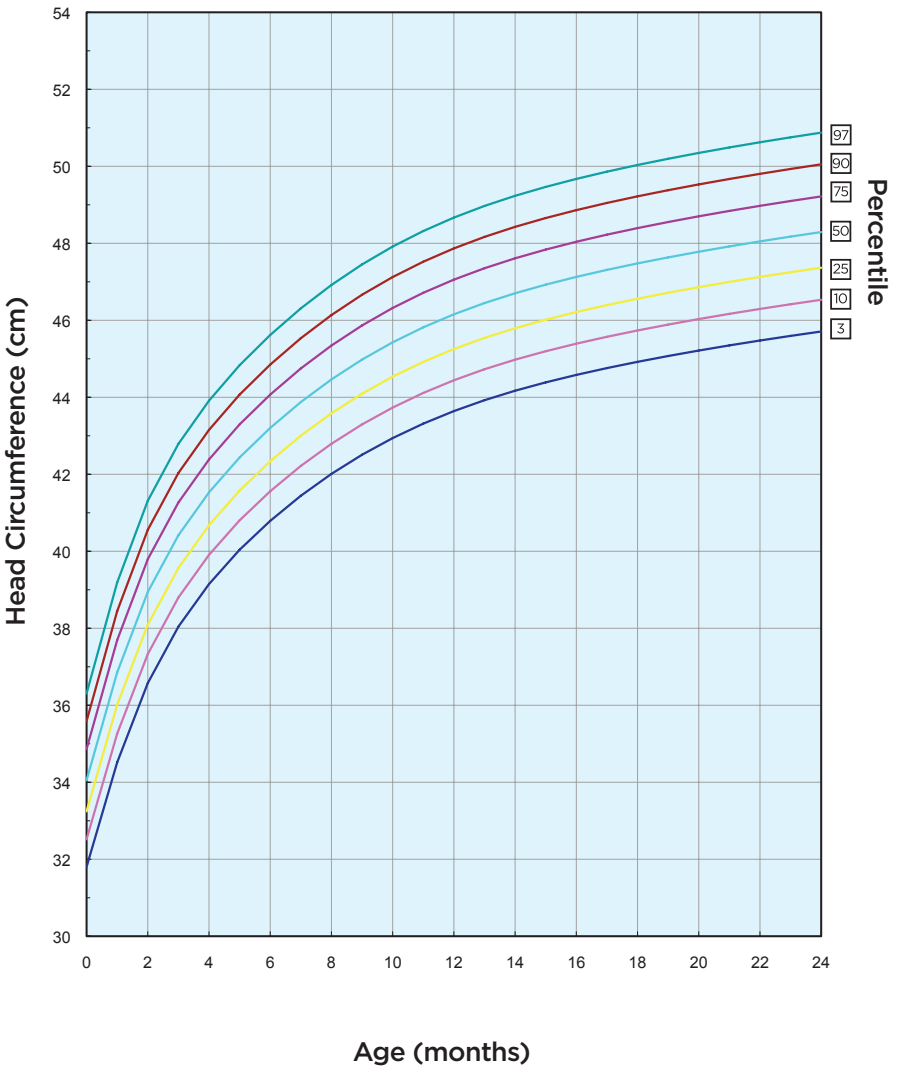
National Healthcare Group Polyclinics

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

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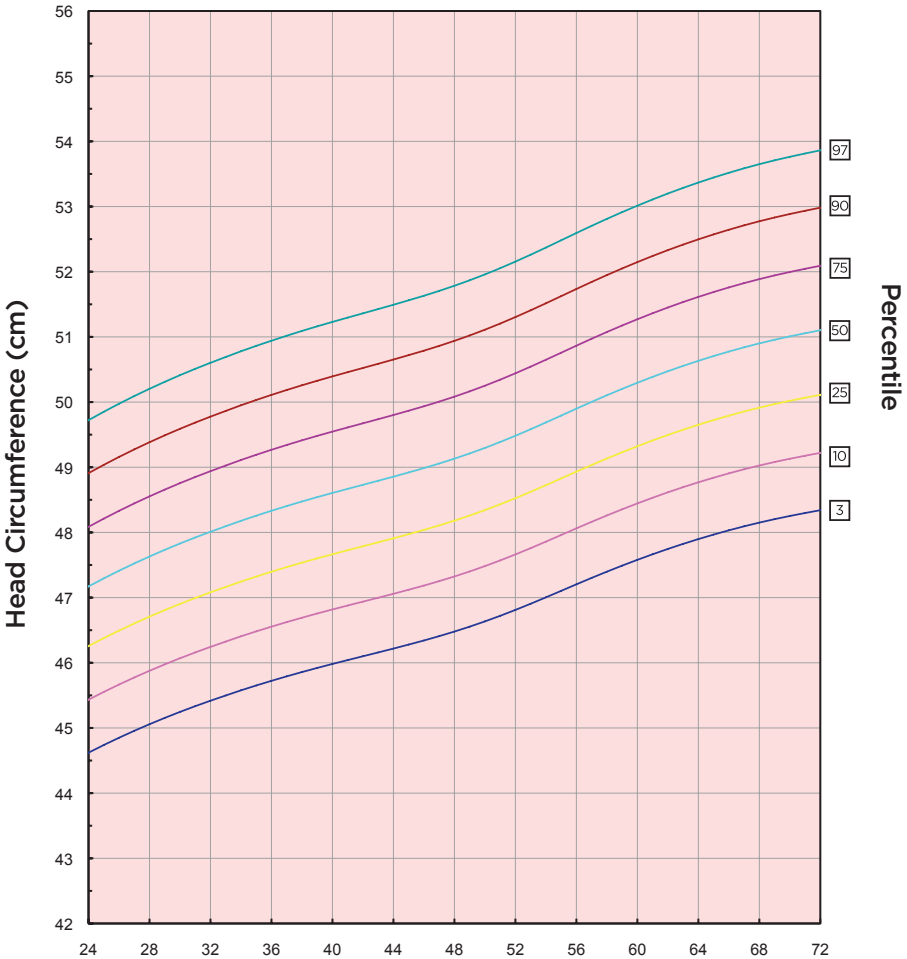
# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE GIRLS AGED 24 TO 72 MONTHS

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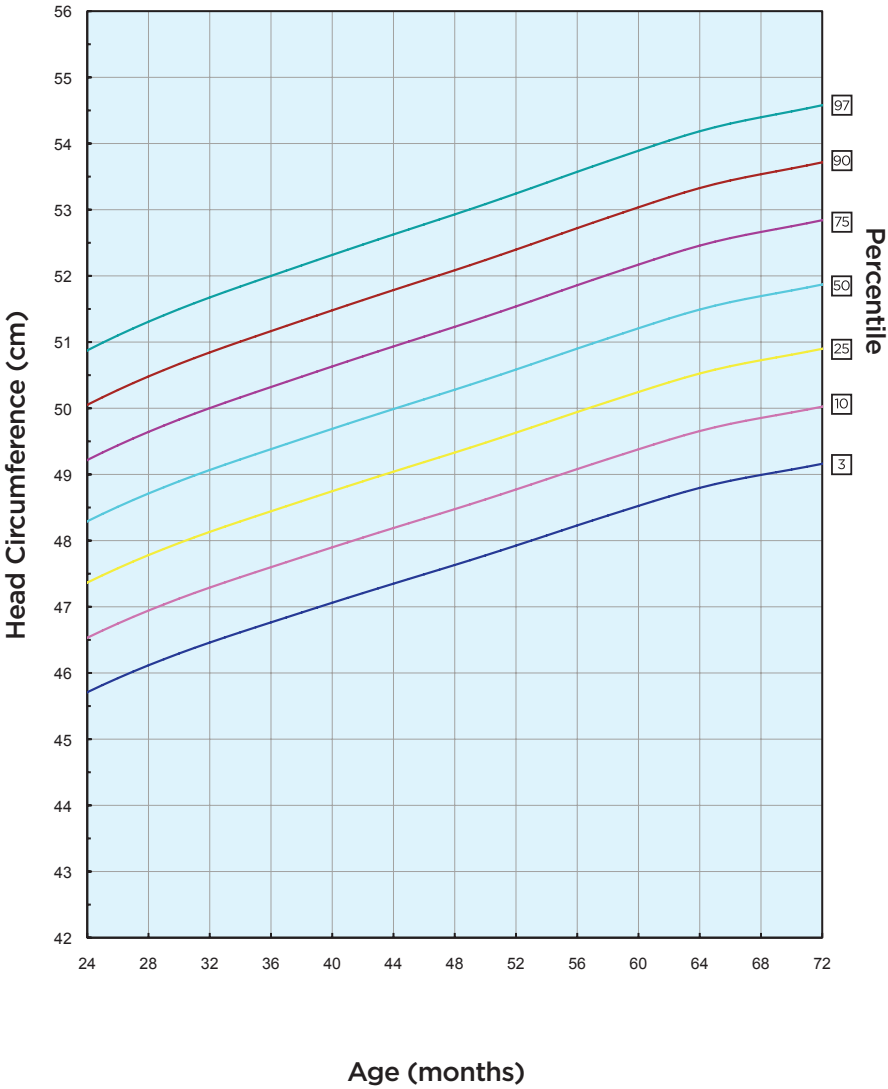
# PERCENTILES OF HEAD CIRCUMFERENCE-FOR-AGE BOYS AGED 24 TO 72 MONTHS

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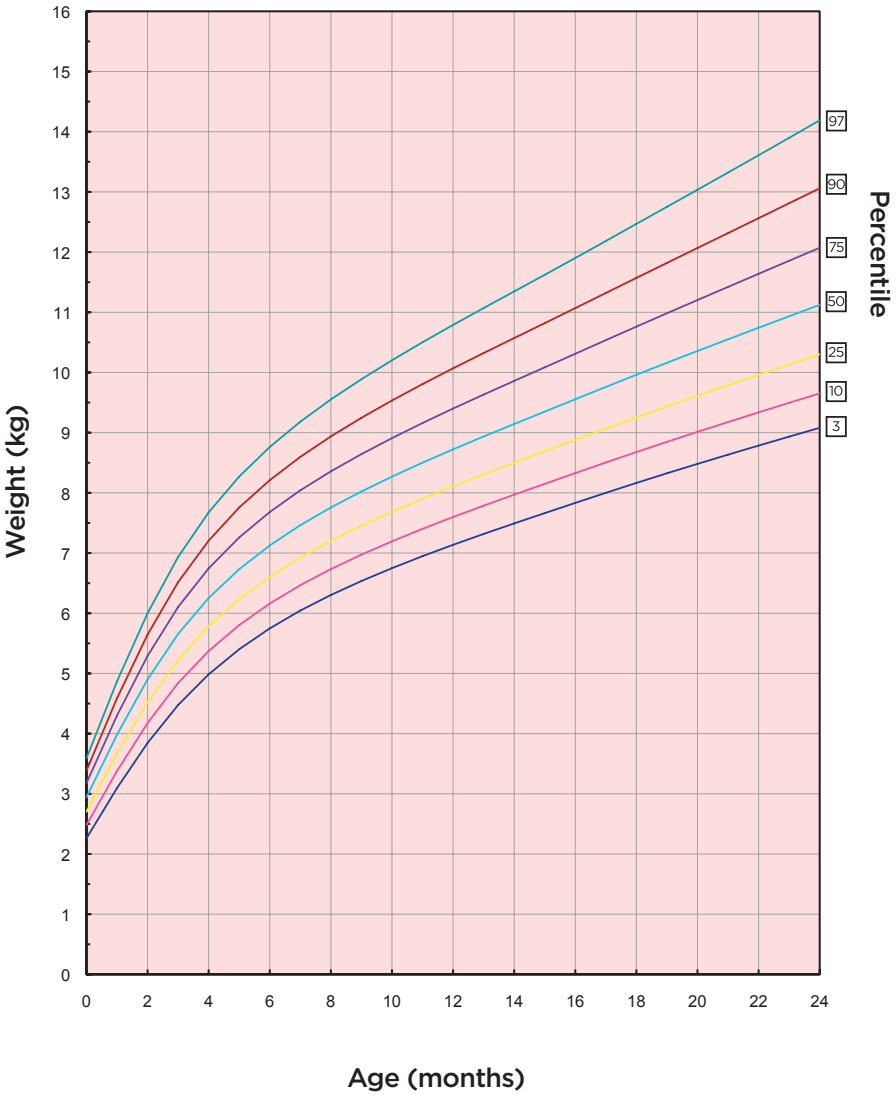


Anthropometric Study on Pre-School Children in Singapore, 2000
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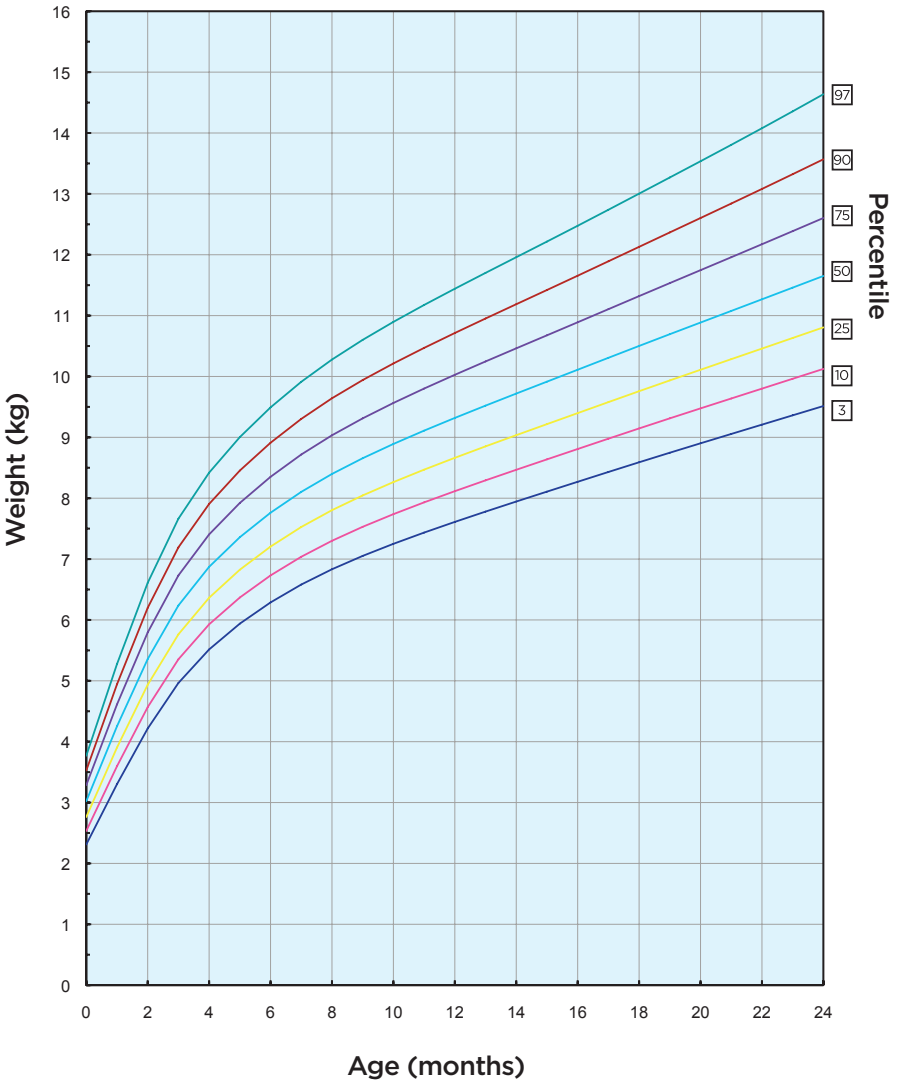
# PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS

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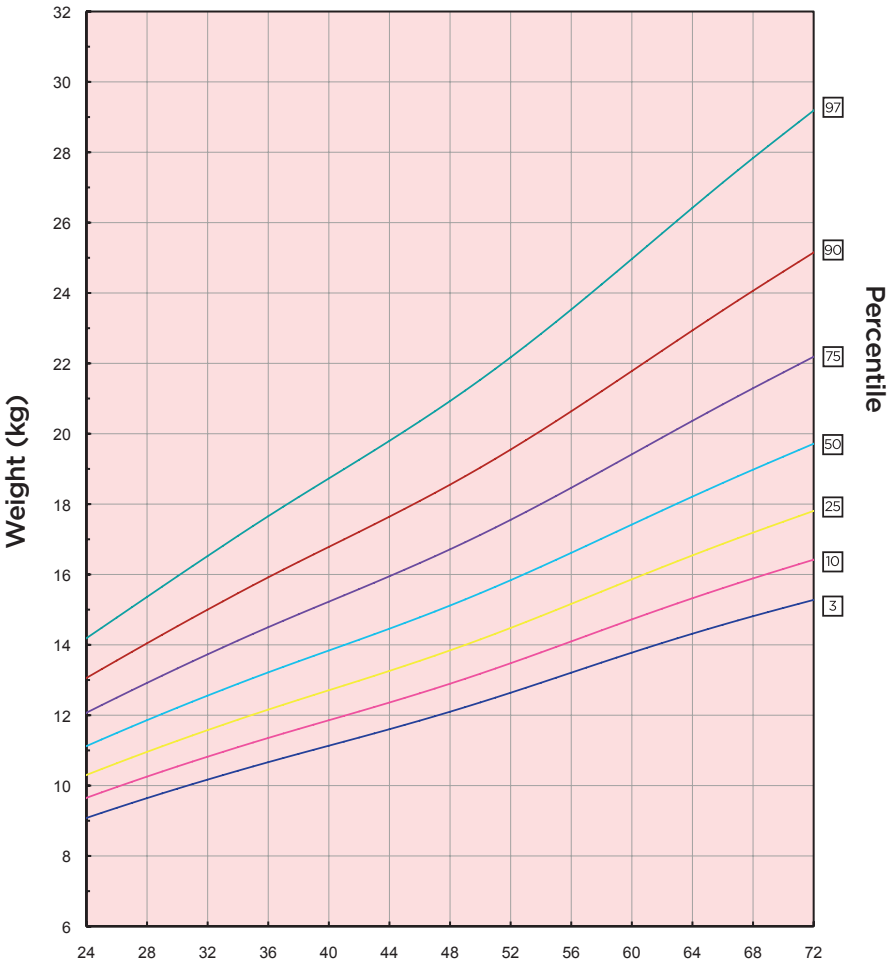
# PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 24 TO 72 MONTHS

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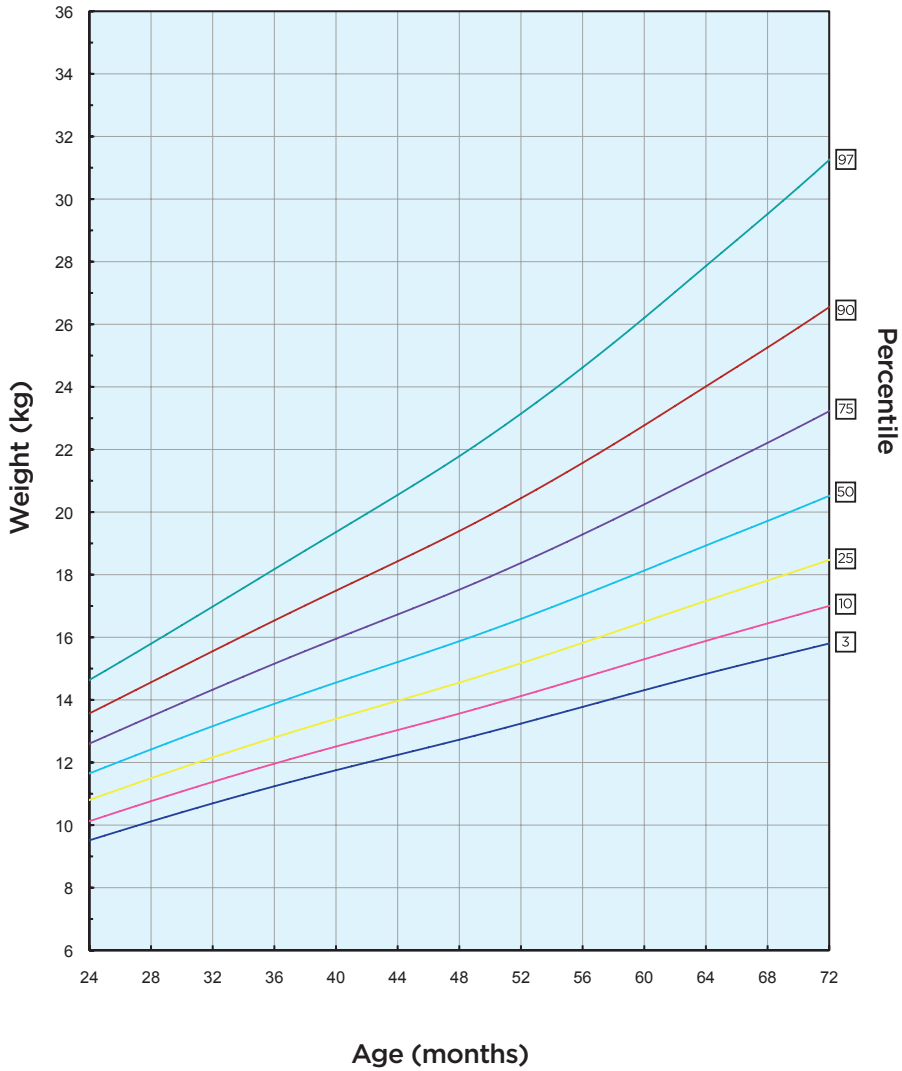


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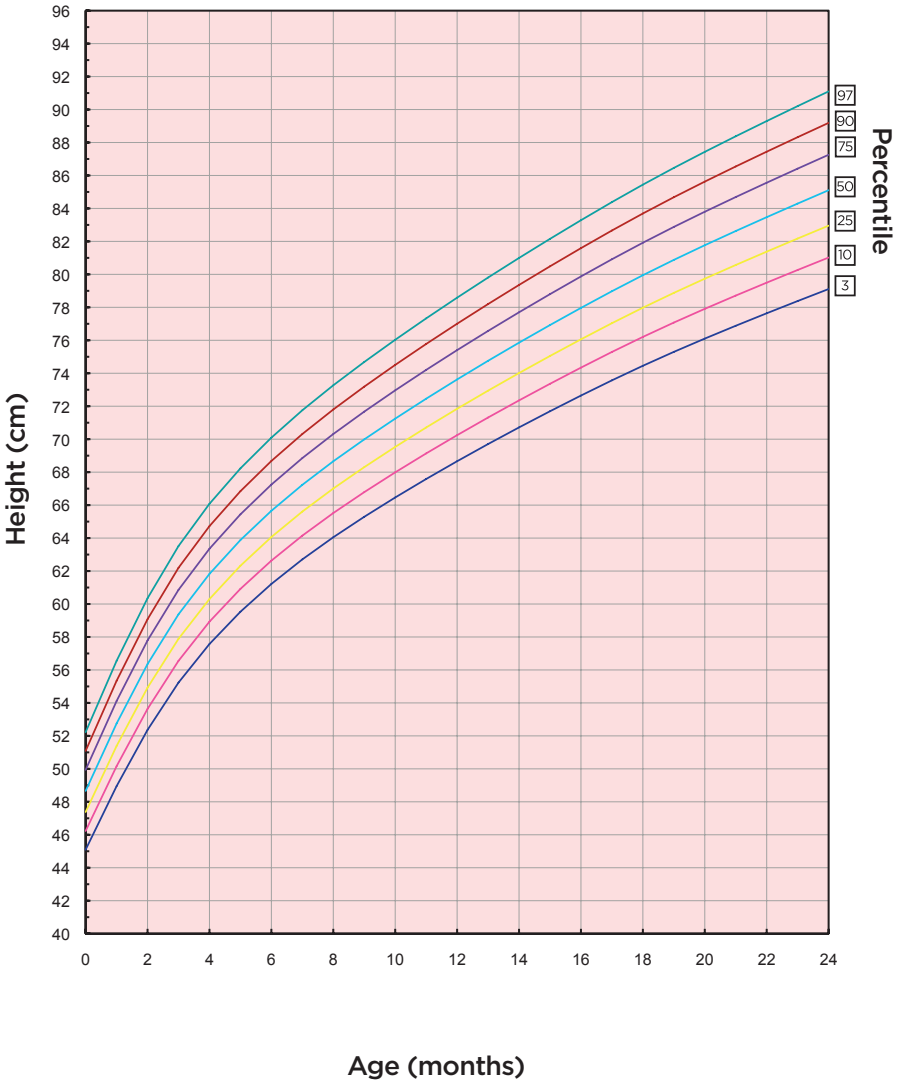


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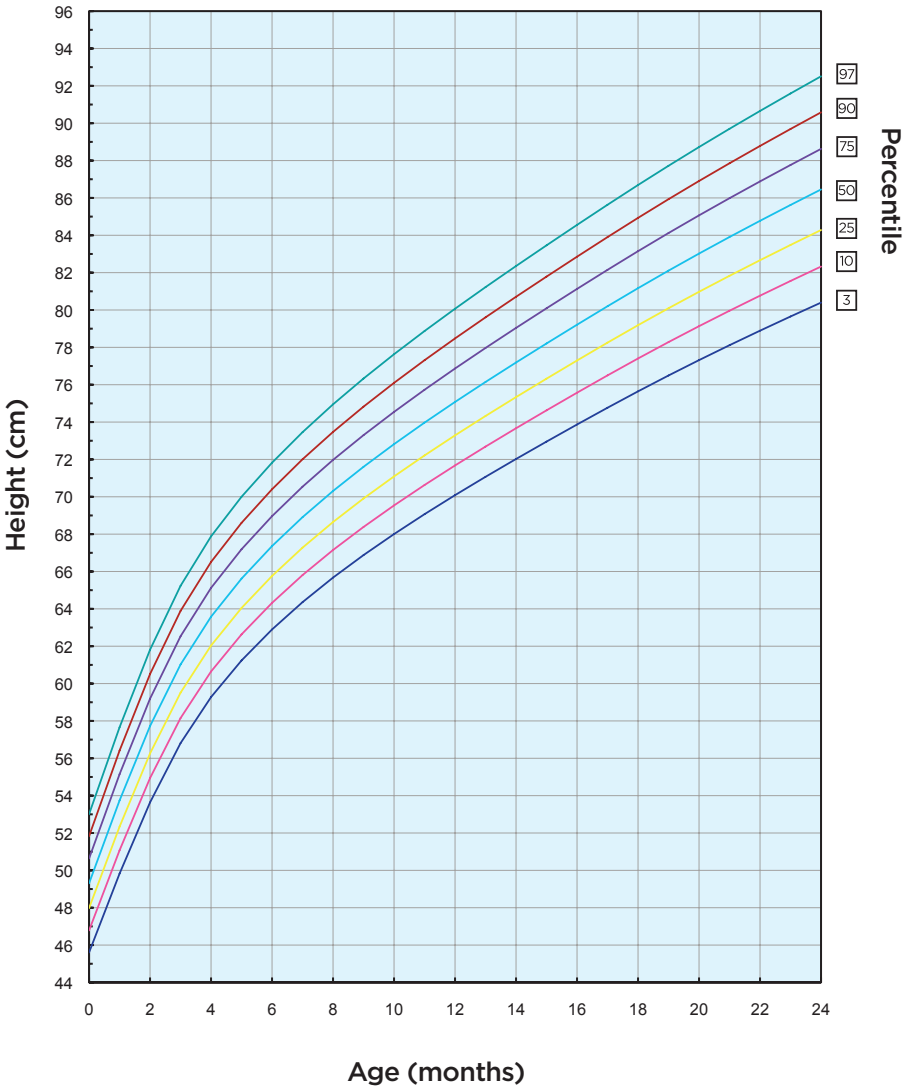
# PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 0 TO 24 MONTHS

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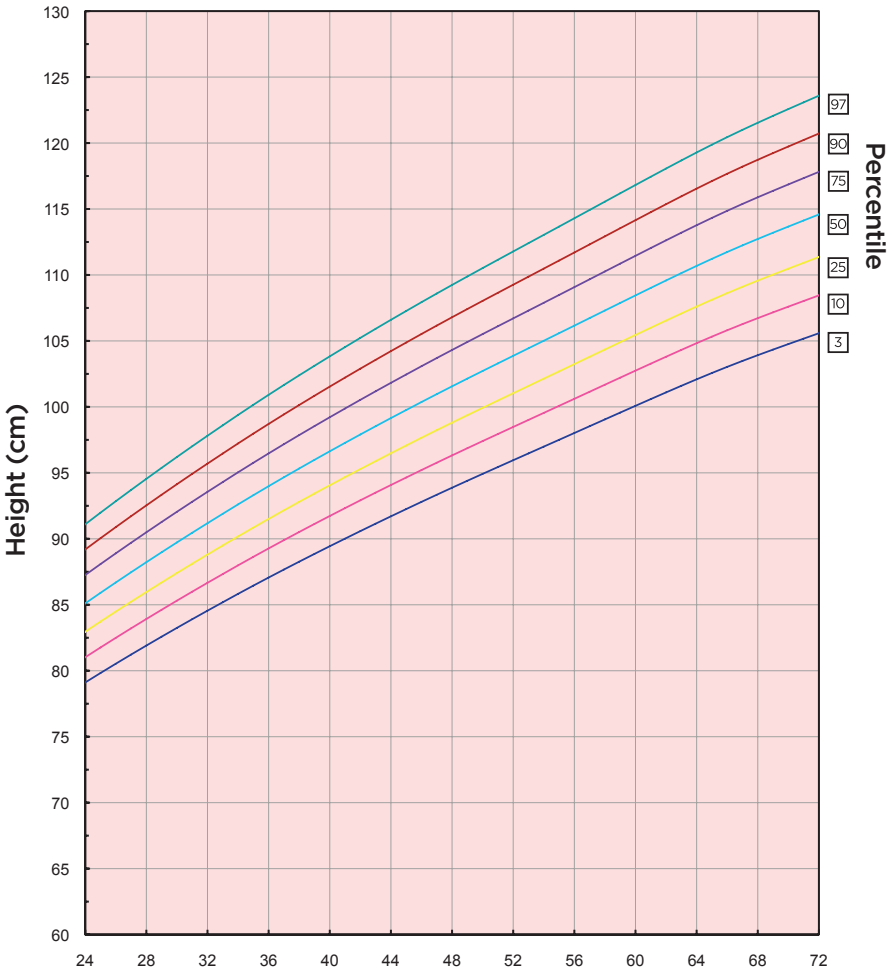


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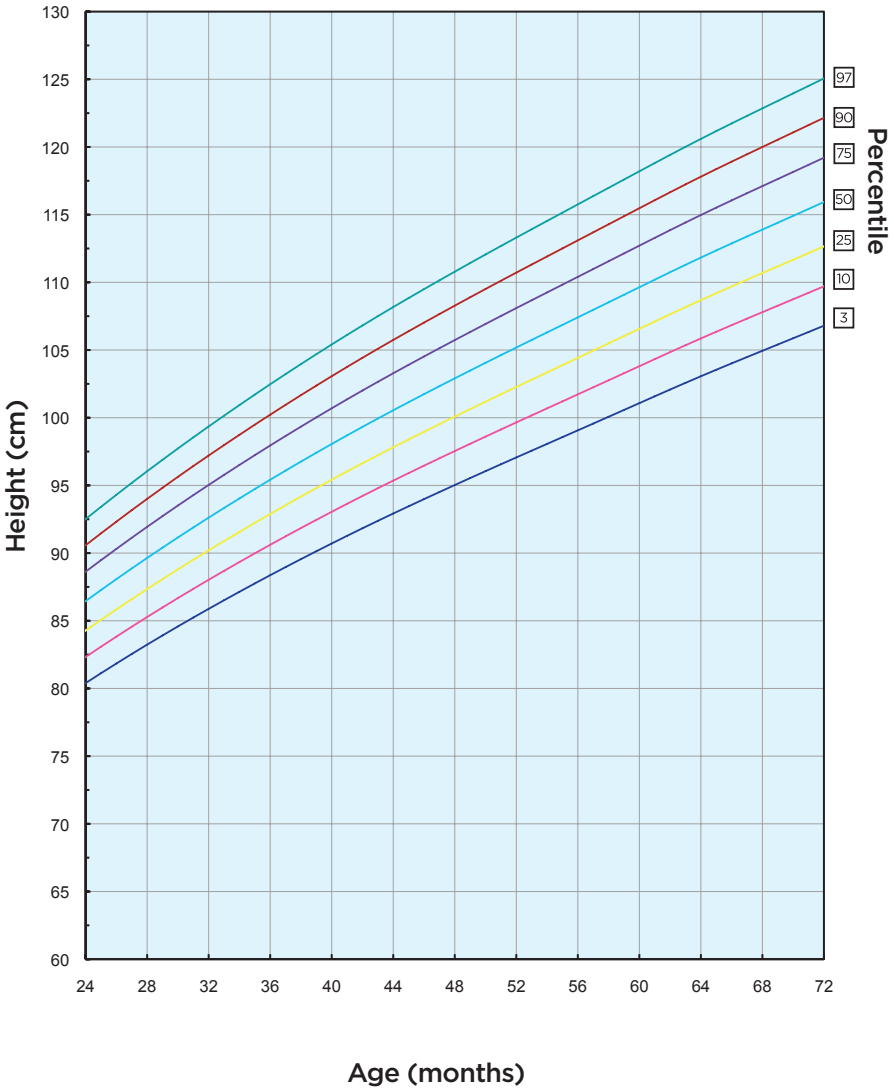


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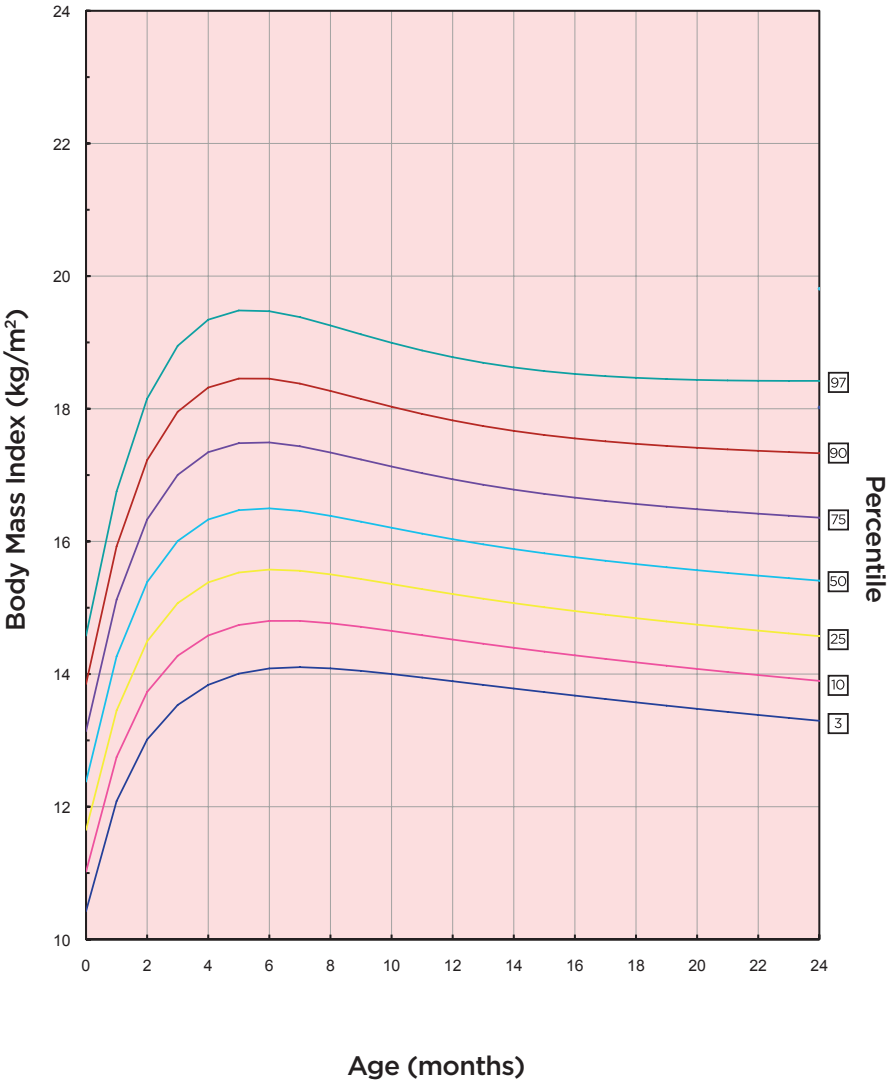
# PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 0-24 MONTHS




Anthropometric Study on Pre-School Children in Singapore, 2000
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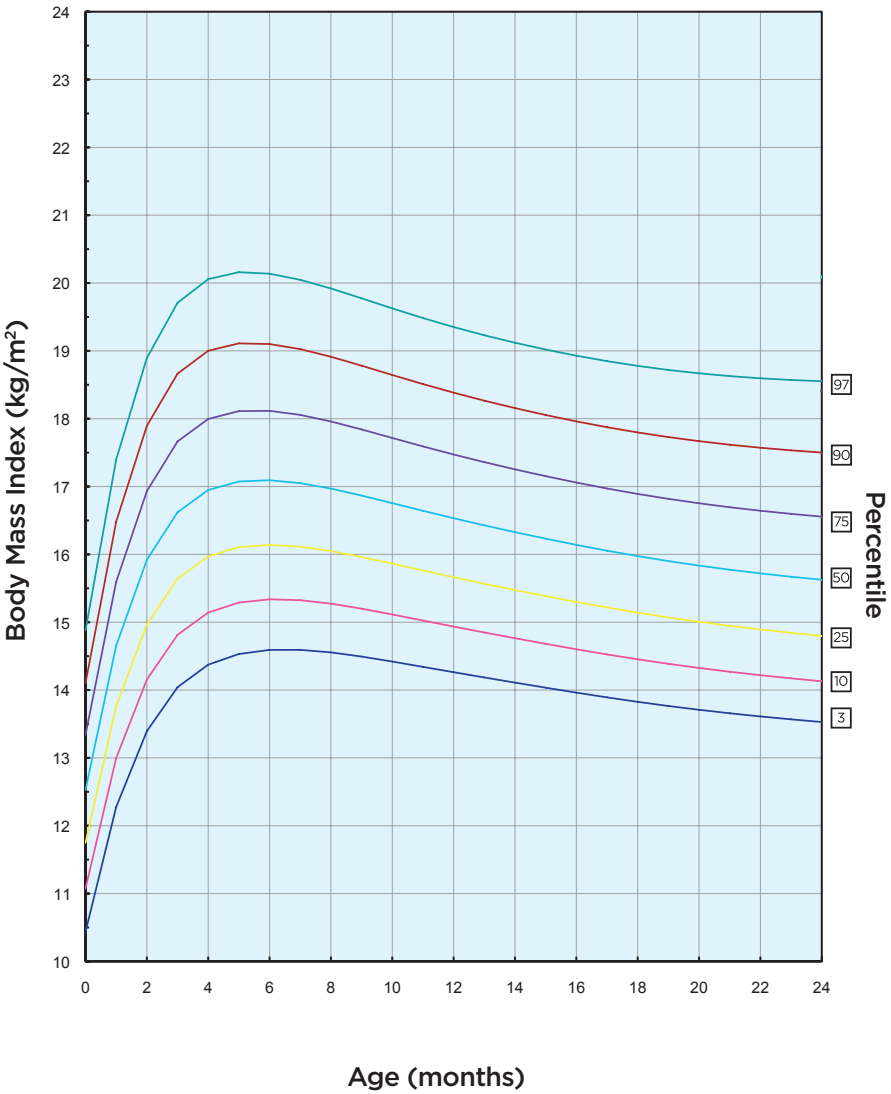
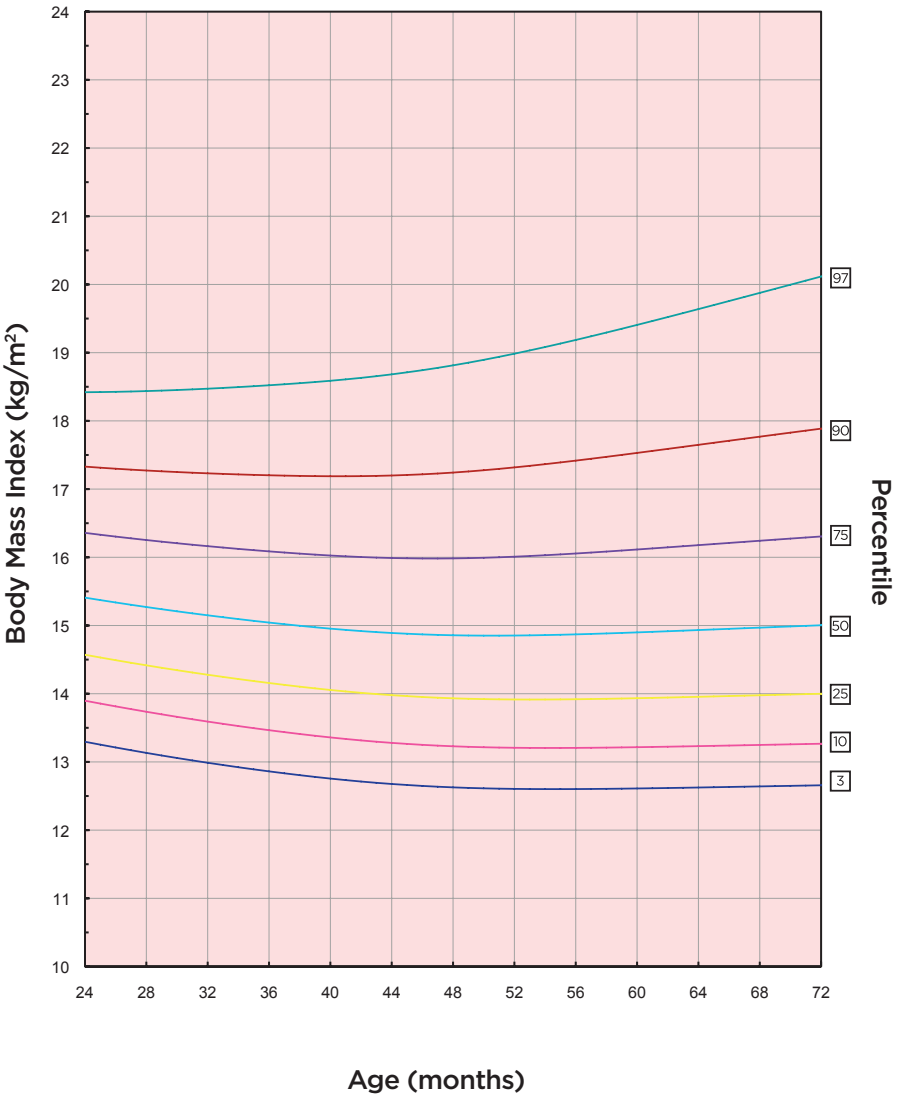
# PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 0-24 MONTHS




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

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




Anthropometric Study on Pre-School Children in Singapore, 2000
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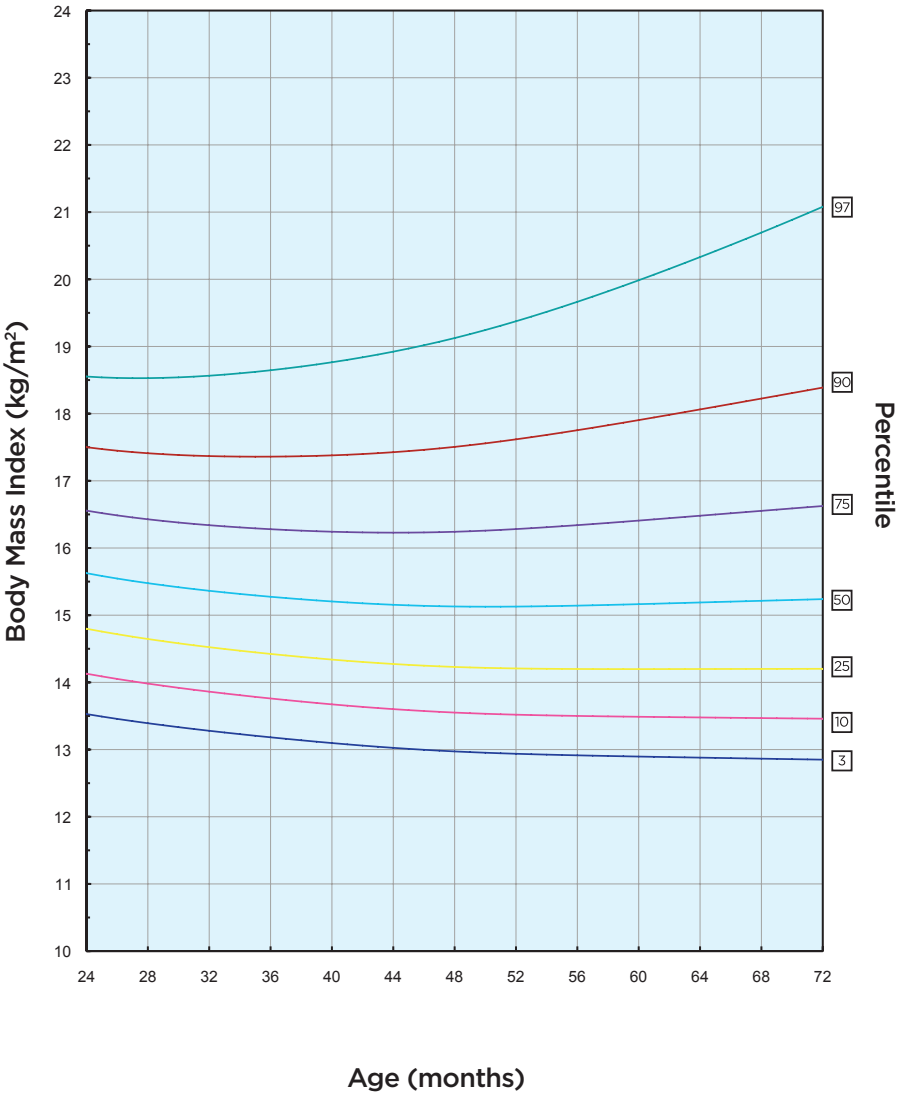
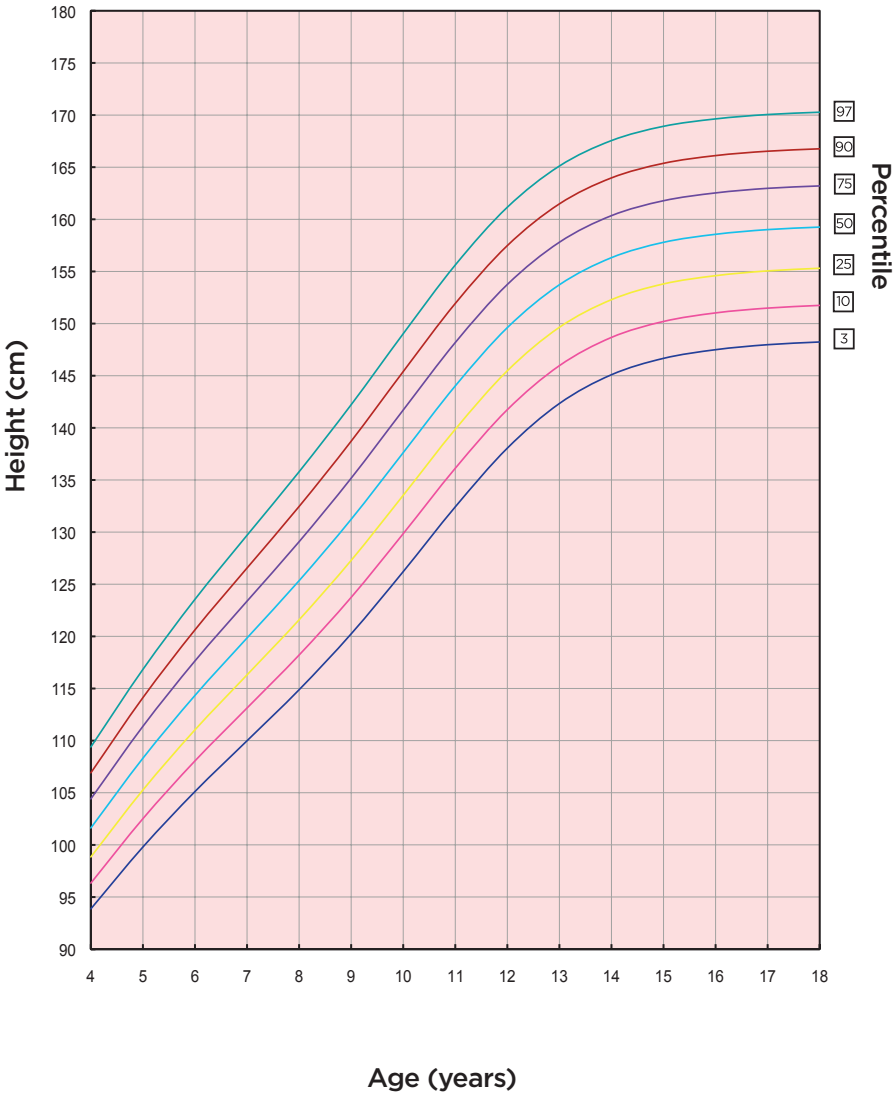



Anthropometric Study on Pre-School Children in Singapore, 2000
National Healthcare Group Polyclinics

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

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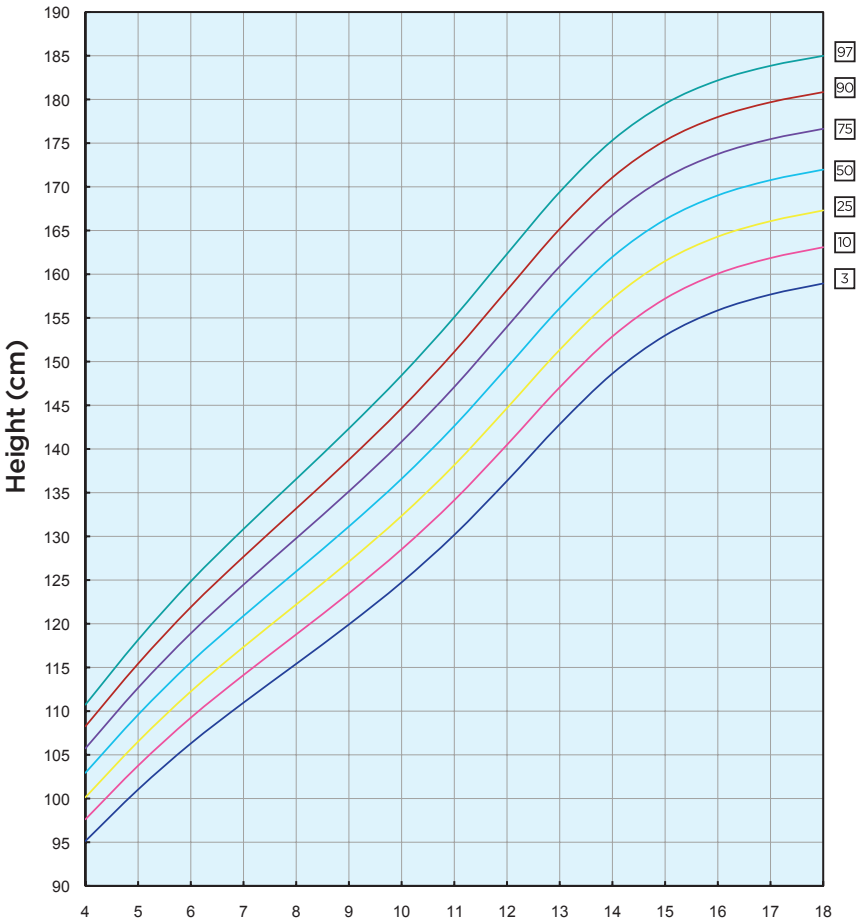
# PERCENTILES OF HEIGHT-FOR-AGE BOYS AGED 4 TO 18 YEARS

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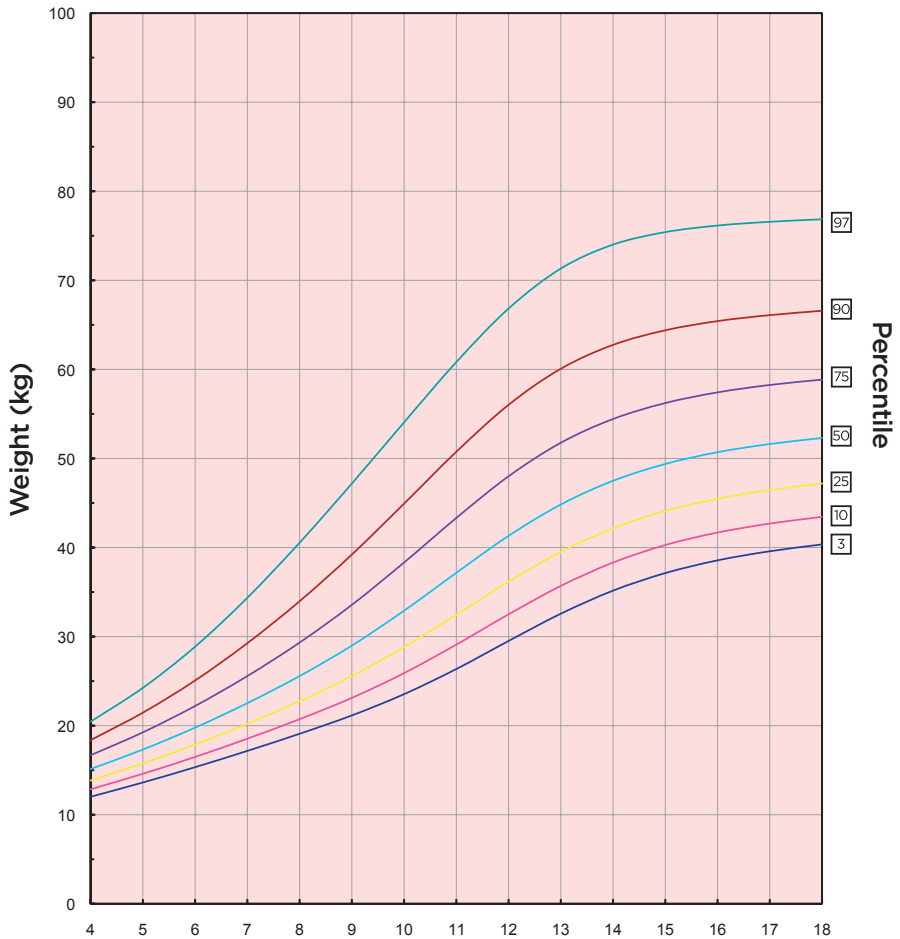
# PERCENTILES OF WEIGHT-FOR-AGE GIRLS AGED 4 TO 18 YEARS

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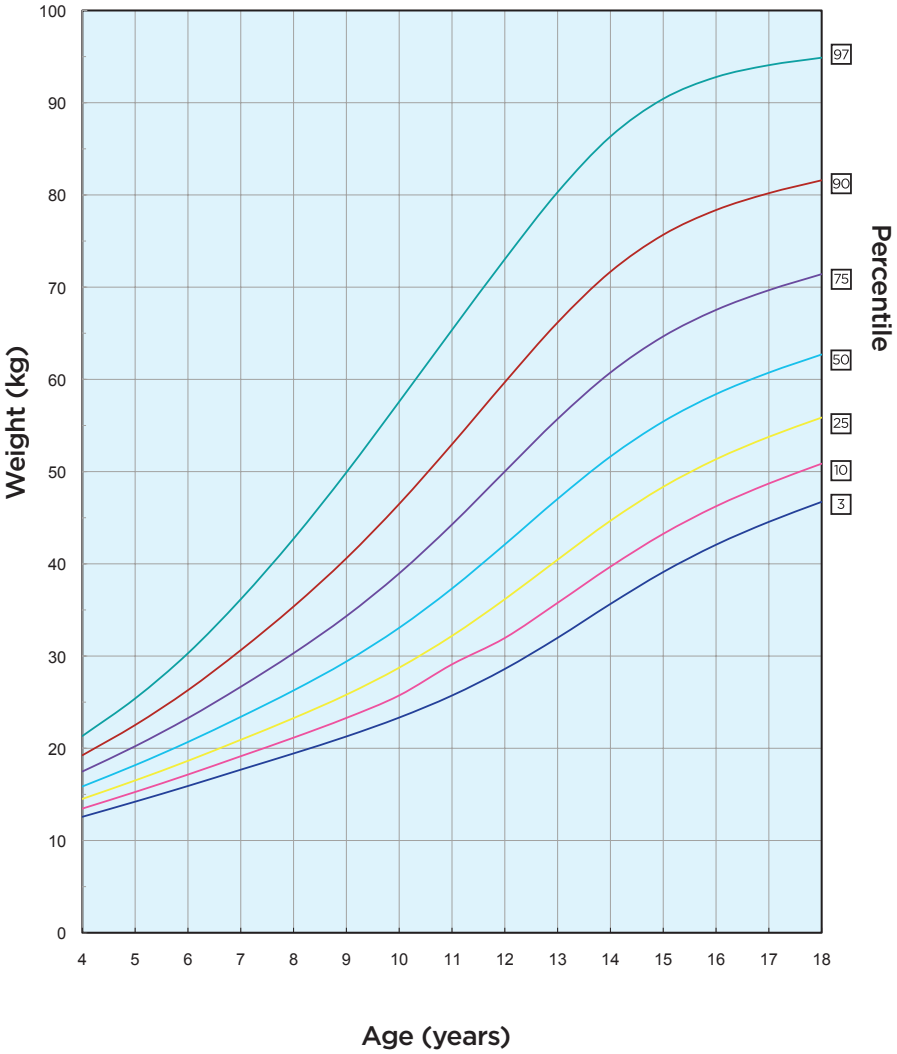
# PERCENTILES OF WEIGHT-FOR-AGE BOYS AGED 4 TO 18 YEARS

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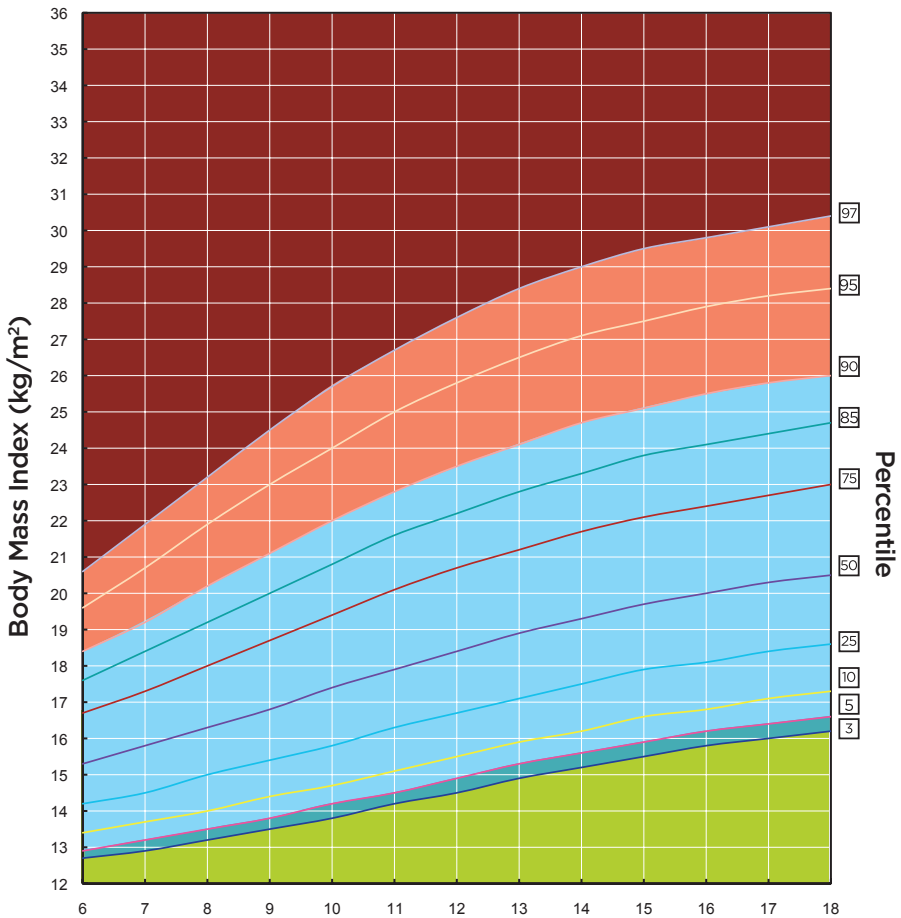
# PERCENTILES OF BODY MASS INDEX-FOR-AGE GIRLS AGED 6 TO 18 YEARS




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

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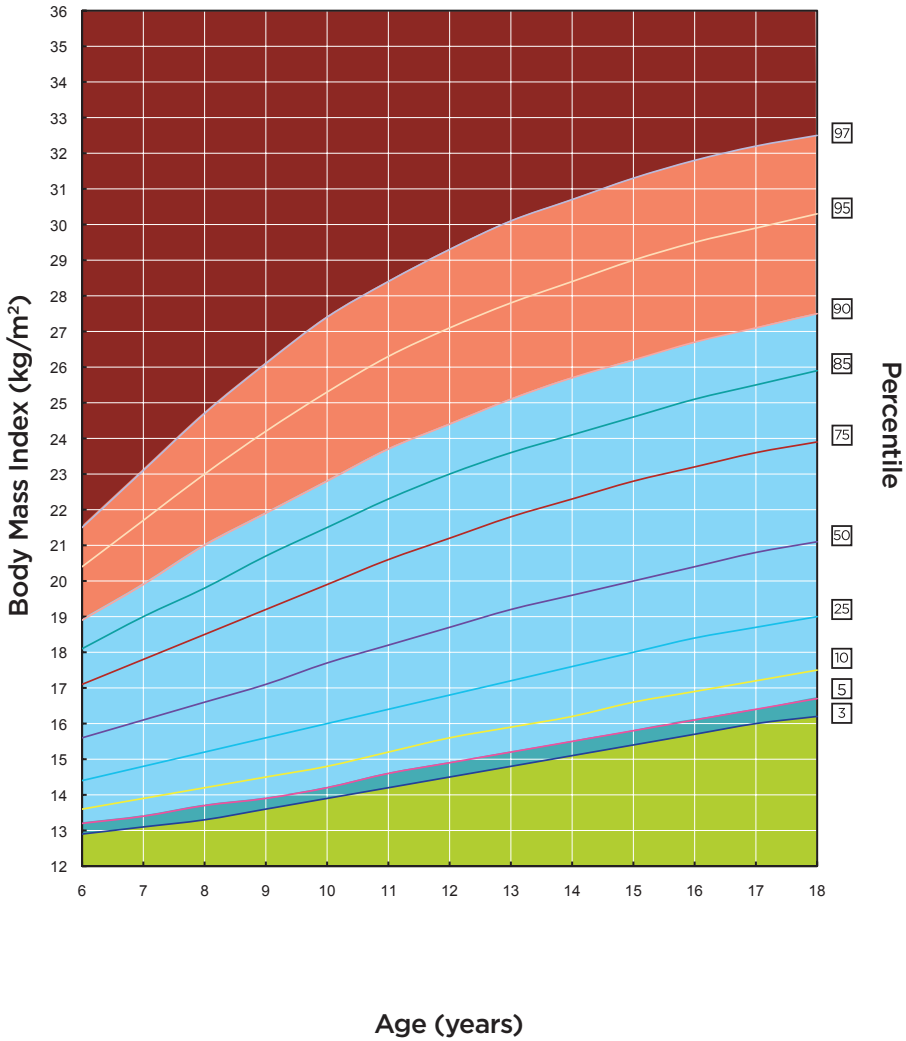
# PERCENTILES OF BODY MASS INDEX-FOR-AGE BOYS AGED 6 TO 18 YEARS




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

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## BMI-for-age for GIRLS aged 6-18 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 |

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## BMI-for-age for BOYS aged 6-18 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 |

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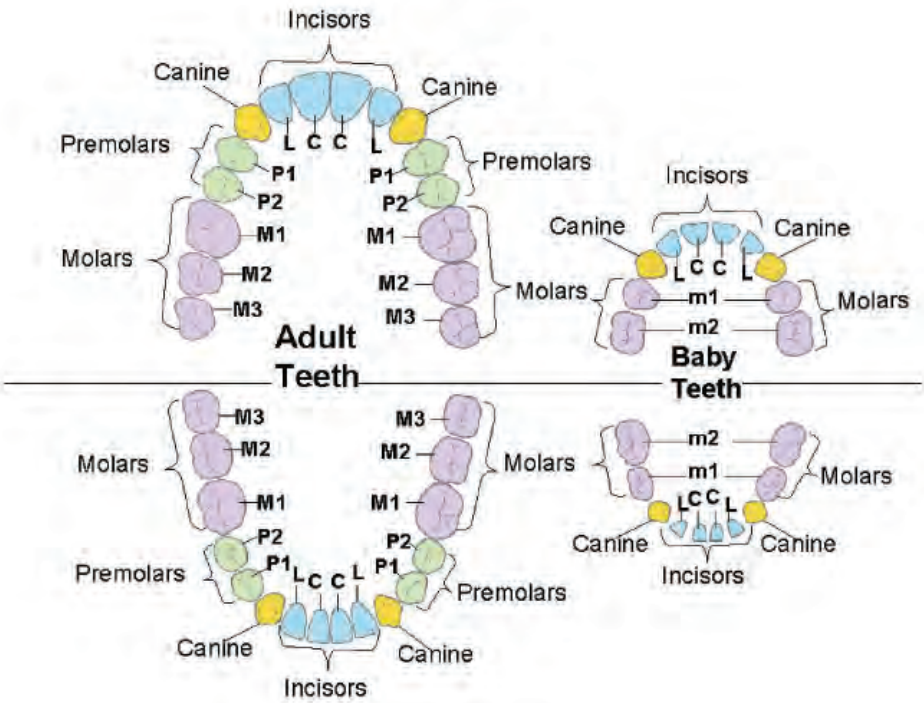
# ORAL HEALTH INFORMATION
# EXPECTED AGE OF TOOTH ERUPTION

| | | TOOTH | EXPECTED AGE OF TOOTH ERUPTION (mths) |
|---|---|---|---|
| BABY TEETH | C | Central Incisor | 6-8 |
| | L | Lateral Incisor | 7-9 |
| | | Canine | 16-18 |
| | m1 | First Molar | 12-14 |
| | m2 | Second Molar | 20-30 |

| | | TOOTH | EXPECTED AGE OF TOOTH ERUPTION (years) |
|---|---|---|---|
| ADULT TEETH | C | Lower Central Incisor | 6-7 |
| | C | Upper Central Incisor | 7-8 |
| | L | Lower Lateral Incisor | |
| | L | Upper Lateral Incisor | 8-9 |
| | | Lower Canine | 9-10 |
| | | Upper Canine | 11-12 |
| | P1 | First Premolar | 10-12 |
| | P2 | Second Premolar | |
| | M1 | First Molar | 6-7 |
| | M2 | Second Molar | 11-13 |
| | M3 | Third Molar | 17-21 |

## UPPER TEETH




## LOWER TEETH

# CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)

## 1. 4-8 weeks

- ☐ I ensure that bolsters, pillows, blankets and plastic bags are kept away from my baby to avoid unintentional suffocation. I always place my baby to sleep on his back.
- ☐ I do not use a sarong cradle for my child nor allow him/her to sleep on the same bed as me, to avoid rolling onto and suffocating him/her. My baby sleeps in a cot which meets safety standards.
- ☐ When preparing the water for my child's bath, I run cold water into the bathtub first followed by hot water, to prevent scalds.
- ☐ I never leave my baby unattended in the bathtub.
- ☐ I ensure that my baby is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
- ☐ I never leave my baby alone in the car.

## 2. 3-5 months

- ☐ I ensure that bolsters, pillows, blankets and plastic bags are kept away from my baby to avoid unintentional suffocation. I always place my baby to sleep on his back.
- ☐ I do not use a sarong cradle for my child. My baby sleeps in a cot which meets safety standards.
- ☐ I ensure that my baby is never left alone on the bed or in a cot without the sides drawn up.
- ☐ I never leave my baby unattended in the bathtub.
- ☐ I ensure that my baby is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
- ☐ I never leave my child alone in the car.

## 3. 6-12 months

- ☐ I ensure that small toy parts and other choking hazards (e.g. coins, pins and buttons) are kept out of my child's reach.
- ☐ I never let my child use a baby walker.
- ☐ I ensure that the window grilles in my home are kept locked at all times.
- ☐ I make sure that my child is never left alone on the bed, in a cot without the sides drawn up, or in a high chair.
- ☐ I keep hot drinks and foods out of my child's reach. I use table mats instead of table cloths.
- ☐ I do not store pails of water in my bathroom.
- ☐ I ensure that my child is safely belted in an age-appropriate rear-facing car seat placed in the back seat when travelling in a car.
- ☐ I never leave my child alone in the car.

# CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)

## 4. 15-18 months

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

## 5. 2-3 years

- ☐ I do not give my child foods such as whole fish balls, whole grapes etc. that may cause choking.
- ☐ I ensure that the following are kept out of my child's reach:
  - ☐ small toy parts and other choking hazards (e.g. coins, pins and buttons)
  - ☐ glassware, sharp tools, electrical equipment, matches, lighters, ashtrays and alcohol
  - ☐ all medicines and household chemicals (which should be stored in child-proof containers or locked cupboards)
- ☐ I do not allow my child to play with plastic bags to avoid suffocation.
- ☐ I ensure that the window grilles in my home are kept locked at all times.
- ☐ I do not allow my child to enter the kitchen.
- ☐ I use non-slip mats in the bathroom.
- ☐ I always supervise my child closely near water, including bathtubs, swimming pools and open bodies of water.
- ☐ I supervise my child closely while in the playground and ensure that he/she uses only equipment that is appropriate to his/her age.

# CHILD SAFETY CHECKLIST (TO BE COMPLETED BY PARENTS)

- ☐ I ensure that my child is safely belted in an age-appropriate car seat placed in the back seat when travelling in a car.
- ☐ I never leave my child alone in the car.
- ☐ I hold on to my child or carry him/her at all times while walking along or crossing the road.

### 6. 4-6 years

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

Some useful numbers to keep in mind:

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

Telephone numbers are valid at the time of revision.

## National Childhood Immunisation Schedule, Singapore

| Vaccination against | Birth | 1 month | 3 months | 4 months | 5 months | 6 months | 12 months | 15 months | 18 months | 10-11 years^ |
|---|---|---|---|---|---|---|---|---|---|---|
| Tuberculosis | BCG | | | | | | | | | |
| Hepatitis B | HepB (D1) | HepB (D2) | | | HepB (D3)# | | | | | |
| Diphtheria, Tetanus, Pertussis | | | DTaP (D1) | DTaP (D2) | DTaP (D3) | | | | DTaP (B1) | Tdap (B2) |
| Poliovirus | | | IPV (D1) | IPV (D2) | IPV (D3) | | | | IPV (B1) | OPV (B2) |
| *Haemophilus influenzae* type b | | | Hib (D1) | Hib (D2) | Hib (D3) | | | | Hib (B1) | |
| Measles, Mumps, Rubella | | | | | | | MMR (D1) | MMR (D2)## | | |
| Pneumococcal Disease | | | PCV (D1) | | PCV (D2) | | PCV (B1) | | | |
| Human Papillomavirus | *Recommended for females 9 to 26 years; three doses are required at intervals of 0, 2, 6 months* | | | | | | | | | |

Notes:

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

**Immunisation for Diphtheria and Measles are COMPULSORY by law.**

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

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

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

For more immunisation information and updates, please check **http://www.nir.hpb.gov.sg/nir/sv/eservices/eservicesv?ACTION=DISPLAY_IMMUNSCH**

# Immunisation Record Of National Childhood Vaccinations

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

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

**Infectious Disease Act**

| Vaccine | Sequence | Site of Vaccination | Brand of Vaccine[1] | Date Given | Batch No. | Name of Clinic/Stamp of Clinic |
|---|---|---|---|---|---|---|
| **BCG** | | | | | | |
| **Hepatitis B[2]** (e.g. Engerix-B, Infanrix-Hexa) | 1st Dose | | | | | |
| | 2nd Dose | | | | | |
| | 3rd Dose | | | | | |
| **Diptheria Pertussis, Tetanus[2]** (e.g. DTap, Infanrix, Infanrix-Hexa, Infanrix-Hib, Infanrix-IPV+Hib) | 1st Dose | | | | | |
| | 2nd Dose | | | | | |
| | 3rd Dose | | | | | |
| | 1st Booster | | | | | |
| | 2nd Booster | | | | | |
| **Polio[2]** (e.g. Polio Sabin, IPV, Infanrix Hexa, Infanrix-IPV+Hib) | 1st Dose | | | | | |
| | 2nd Dose | | | | | |
| | 3rd Dose | | | | | |
| | 1st Booster | | | | | |
| | 2nd Booster | | | | | |
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|---|---|---|---|---|---|---|
| ***Haemophilus influenzae* type b[2]** (e.g. Infanrix-Hib, Infanrix Hexa) | 1st Dose | | | | | |
| | 2nd Dose | | | | | |
| | 3rd Dose | | | | | |
| | 1st Booster | | | | | |
| **Pneumococcal conjugate vaccine** (e.g. Synflorix, Prevenar 13) | 1st Dose | | | | | |
| | 2nd Dose | | | | | |
| | 3rd Dose *(if needed)* | | | | | |
| | Booster | | | | | |
| **Measles, Mumps, Rubella** (e.g. M-M-R II, Priorix, Priorix-Tetra) | 1st Dose | | | | | |
| | 2nd Dose/Booster | | | | | |
| **Human Papilloma Virus** (e.g. Gardasil, Cervarix) Recommended | | | | | | |
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**CONTRAINDICATIONS/REACTIONS TO VACCINES:**

Footnote:

How to complete this record
1. Record the generic abbreviation (e.g. Tdap) or the trade name for each vaccine under the "Brand of Vaccine".
2. Fill in the respective individual antigen in the combination vaccines in the appropriate rows.
3. Please fill in under "Site of vaccination" – "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".

# Immunisation Record Of Optional Vaccinations

| Vaccine | Sequence | Site of Vaccination | Brand of Vaccine[1] | Date Given | Batch No. | Name of Clinic/Stamp of Clinic |
|---|---|---|---|---|---|---|
| **Rotavirus** (e.g. Rotarix, Rotateq) | | Oral | | | | |
| | | Oral | | | | |
| | | Oral | | | | |
| **Chicken Pox**[2] (e.g. Varilix) | | | | | | |
| | | | | | | |
| **Hepatitis A**[2] (e.g. Twinrix, Havrix) | | | | | | |
| | | | | | | |
| **Meningococcus** (e.g. Mencevax ACWY, Menactra) | | | | | | |
| | | | | | | |
| **Influenza** (e.g. Influvac) | | | | | | |
| | | | | | | |
| **Others** (Specify) | | | | | | |
| | | | | | | |

**CONTRAINDICATIONS/REACTIONS TO VACCINES:**

Footnote:

How to complete this record
1. Record the generic abbreviation (e.g. Tdap) or the trade name for each vaccine under the "Brand of Vaccine".
2. Fill in the respective individual antigen in the combination vaccines in the appropriate rows.
3. Please fill in under "Site of vaccination" – "left deltoid", "right deltoid", "left anterolateral thigh", "right anterolateral thigh", "left buttock" or "right buttock".

## Summary of Clinic / Hospital Medical Records

| Date | Clinic/Hospital | Diagnosis | Management | Name and Signature of Doctor |
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## Summary of Clinic / Hospital Medical Records

| Date | Clinic/Hospital | Diagnosis | Management | Name and Signature of Doctor |
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## Summary of Clinic / Hospital Medical Records

| Date | Clinic/Hospital | Diagnosis | Management | Name and Signature of Doctor |
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## Summary of Clinic / Hospital Medical Records

| Date | Clinic/Hospital | Diagnosis | Management | Name and Signature of Doctor |
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# 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 |
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## Acknowledgements

The Health Promotion Board would like to express our sincere thanks to the following healthcare institutions for their contributions to the revision of the health booklet:

- **Gleneagles Hospital**
- **KK Women's and Children's Hospital**
- **Mount Alvernia Hospital**
- **Mount Elizabeth Hospital**
- **National Healthcare Group Polyclinics**
- **National University Hospital**
- **Parkway East**
- **Raffles Hospital**
- **Singapore General Hospital**
- **SingHealth Polyclinics**
- **Thomson Medical Centre**