



60 Month Questionnaire

57 months 0 days
through 66 months 0 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

Notes:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by _____.

COMMUNICATION

YES SOMETIMES NOT YET _____

1. Without your giving help by pointing or repeating directions, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."

2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:

3. When talking about something that already happened, does your child use words that end in "-ed," such as "walked," "jumped," or "played"? Ask your child questions, such as "How did you get to the store?" ("We walked.") "What did you do at your friend's house?" ("We played.") Please write an example:

4. Does your child use comparison words, such as "heavier," "stronger," or "shorter"? Ask your child questions, such as "A car is big, but a bus is _____" (bigger); "A cat is heavy, but a man is _____" (heavier); "A TV is small, but a book is _____" (smaller). Please write an example:

COMMUNICATION (continued)

YES SOMETIMES NOT YET _____

5. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include: "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:

6. Does your child repeat the sentences shown below back to you, without any mistakes? (Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)

Jane hides her shoes for Maria to find.
Al read the blue book under his bed.

COMMUNICATION TOTAL _____

GROSS MOTOR

YES SOMETIMES NOT YET _____

1. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")



2. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)



3. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)




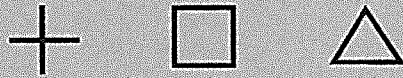
GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 4. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? (You may show him how to do this.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child hop forward on one foot for a distance of 4–6 feet without putting down the other foot? (You may give her two tries on each foot. Mark "sometimes" if she can hop on one foot only.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child skip using alternating feet? (You may show him how to do this.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? (Mark "sometimes" if your child goes off the line three times.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| _____ | | | | |
| 2. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, and legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|  | | | | |
| 4. Using the shapes below to look at, does your child copy the shapes in the space below without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size. Mark "yes" if she copies all three shapes; mark "sometimes" if your child copies two shapes.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



(Space for child's shapes)

FINE MOTOR (continued)

YES SOMETIMES NOT YET _____

5. Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. (Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.)

V H T C A

(Space for child's letters)

6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. (Mark "sometimes" if your child copies about half of the letters.)

(Space for adult's printing)

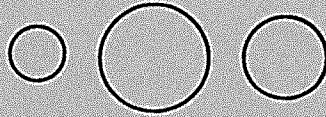
(Space for child's printing)

FINE MOTOR TOTAL _____

PROBLEM SOLVING

YES SOMETIMES NOT YET _____

1. When asked, "Which circle is smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)



2. When shown objects and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.)

PROBLEM SOLVING *(continued)*

YES SOMETIMES NOT YET _____

- 3. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes."
- 4. Does your child finish the following sentences using a word that means the opposite of the word that is italicized? For example: "A rock is *hard*, and a pillow is *soft*."

Please write your child's responses below:

A cow is *big*, and a mouse is

Ice is *cold*, and fire is

We see stars at *night*, and we see the sun during the

When I throw the ball *up*, it comes

(Mark "yes" if he finishes three of four sentences correctly. Mark "sometimes" if he finishes two of four sentences correctly.)

- 5. Does your child know the names of numbers? *(Mark "yes" if she identifies the three numbers below. Mark "sometimes" if she identifies two numbers.)*

3 1 2

- 6. Does your child name at least four letters in her name? Point to the letters and ask, "What letter is this?" *(Point to the letters out of order.)*

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

YES SOMETIMES NOT YET _____

- 1. Can your child serve himself, taking food from one container to another, using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?
- 2. Does your child wash her hands and face using soap and water and dry off with a towel without help?
- 3. Does your child tell you at least four of the following? Please mark the items your child knows.

- a. First name
- b. Age
- c. City he lives in
- d. Last name
- e. Boy or girl
- f. Telephone number

PERSONAL-SOCIAL (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child use the toilet by herself? (She goes to the bathroom, sits on the toilet, wipes, and flushes.) Mark "yes" even if she does this after you remind her. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child usually take turns and share with other children? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PERSONAL-SOCIAL TOTAL —

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

 YES NO

2. Do you think your child talks like other children her age? If no, explain:

 YES NO

3. Can you understand most of what your child says? If no, explain:

 YES NO

4. Can other people understand most of what your child says? If no, explain:

 YES NO

OVERALL *(continued)*

5. Do you think your child walks, runs, and climbs like other children his age?
If no, explain:

 YES NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

 YES NO

7. Do you have any concerns about your child's vision? If yes, explain:

 YES NO

8. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

9. Do you have any concerns about your child's behavior? If yes, explain:

 YES NO

10. Does anything about your child worry you? If yes, explain:

 YES NO



60 Month ASQ-3 Information Summary

57 months 0 days through
66 months 0 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.19		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	31.28		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|---|-----|-----------|---|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
Comments: | YES | No |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.

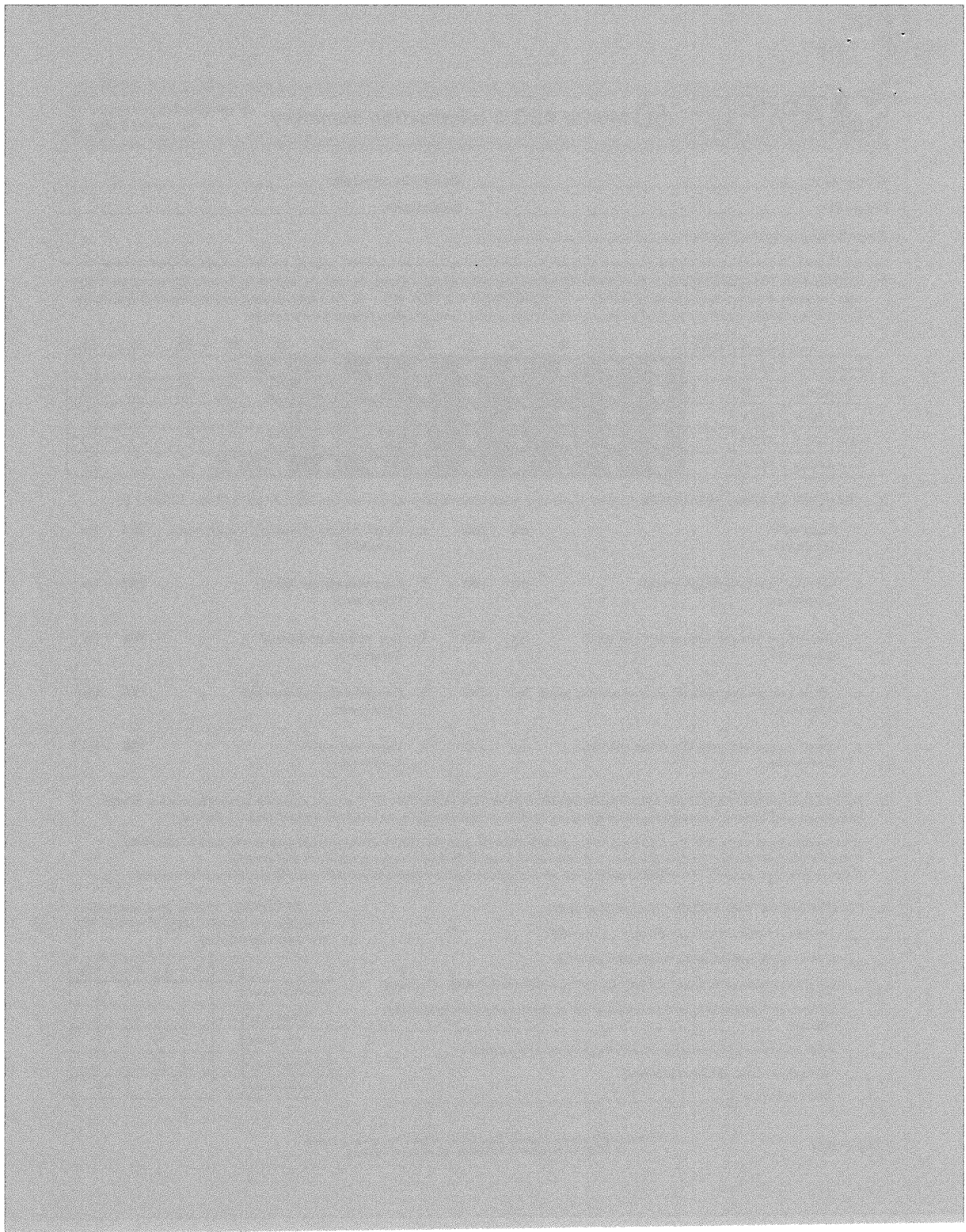
If the child's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

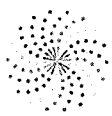
- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim
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60 Month/5 Year Questionnaire



(For children ages 54 through 65 months)



Important Points to Remember:

- Please return this questionnaire by _____ .
- If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- Thank you for your participation in this project.



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
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60 Month/5 Year ASQ:SE Questionnaire

(For children ages 54 through 65 months)



Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

Administering program or provider: _____



Please read each question carefully and

1. Check the box that best describes your child's behavior *and*
2. Check the circle if this behavior is a concern

MOST
OF THE
TIME

SOMETIMES

RARELY
OR
NEVER

CHECK IF
THIS IS A
CONCERN

1. Does your child look at you when you talk to her?

z

v

x

2. Does your child cling to you more than you expect?

x

v

z

3. Does your child like to be hugged or cuddled?



z

v

x

4. Does your child talk and/or play with adults he knows well?

z

v

x

5. When upset, can your child calm down within 15 minutes?

z

v

x

6. Does your child seem too friendly with strangers?

x

v

z

7. Can your child settle herself down after periods of exciting activity?

z

v

x

8. Does your child seem happy?

z

v

x

9. Does your child cry, scream, or have tantrums for long periods of time?

x

v

z

TOTAL POINTS ON PAGE ____

MOST OF THE TIME RARELY OR NEVER CHECK IF THIS IS A CONCERN

10. Is your child interested in things around him, such as people, toys, and foods?



z v x

11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)



z v x

12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)

x v z

13. Can your child stay with activities he enjoys for at least 15 minutes (not including watching television)?

z v x

14. Do you and your child enjoy mealtimes together?

z v x

15. Does your child do what you ask her to do?

z v x

16. Does your child seem more active than other children his age?

x v z

17. Does your child sleep at least 8 hours in a 24-hour period?

z v x

TOTAL POINTS ON PAGE —

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child use words to describe his feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child follow rules (at home, at child care)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
--	------------------------	-----------	-----------------------	----------------------------------

26. Does your child stay away from dangerous things, such as fire and moving cars?

z v x

27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?

z v x

28. Do *other* children like to play with your child?



z v x

29. Does *your child* like to play with other children?

z v x

30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

x v z

31. Does your child take turns and share when playing with other children?

z v x

32. Does your child show an interest or knowledge of adult sexual language and activity?

x v z

33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

x v z

TOTAL POINTS ON PAGE ____

34. Do you have concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

35. Is there anything that worries you about your child? If so, please explain:

36. What things do you enjoy most about your child?

60 Month/5 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____
 Person filling out the ASQ:SE: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ:SE completion: _____
 Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points
 V (for Roman numeral V) next to the checked box = 5 points
 X (for Roman numeral X) next to the checked box = 10 points
 Checked concern = 5 points

Add together:

Total points on page 3 = _____
 Total points on page 4 = _____
 Total points on page 5 = _____
 Total points on page 6 = _____

Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
 Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
 In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
60 months/5 years	70	

3. *Referral criteria*
 Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
 It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
 - Setting/time factors
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
 - Development factors
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
 - Health factors
(e.g., Is the child's behavior related to health or biological factors?)
 - Family/cultural factors
(e.g., Is the child's behavior acceptable given cultural or family context?)



PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider: _____ Phone: _____ Date: _____

Child's Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ City: _____ State: _____ County: _____

Sex: Male Female Hispanic: No Yes Race: White Black Asian Am. Indian/Nat. Alaskan Other _____

US Born: Yes No If no, US Date of Arrival: ____ / ____ / ____ Country of Birth: _____

Parent/Guardian: _____ Phone: _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of country: _____
6. Is the child exposed to a person who: <ul style="list-style-type: none"> • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.

MEDICAL INFORMATION:

Primary Reason for Evaluation: Contact Investigation Targeted Testing Immigration Exam
 Incidental Abnormal CXR/CT Incidental Lab Result
 Other: _____

Symptomatic: No Yes If Yes, ONSET date: ____/____/____

Symptoms: Cough Hemoptysis Fever Night Sweats Weight Loss of ____ lbs.
 Other: _____

Tuberculin Skin Test (TST/Mantoux/PPD) Date Given: ____/____/____ Date Read: ____/____/____	Induration: ____ mm Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Interferon Gamma Release Assay (IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Chest X-ray (required with positive TST or IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal findings
<input type="checkbox"/> LTBI treatment (Rx and start date): Rx: _____ Date: ____/____/____ <input type="checkbox"/> Contraindications to INH or rifampin for LTBI	<input type="checkbox"/> Prior TB/LTBI treatment (Rx and duration): Rx: _____ mm <input type="checkbox"/> Offered but refused LTBI treatment

ADDITIONAL COMMENTS:

RECOMMENDATIONS:

Health Provider Signature: _____

Date Completed: ____/____/____



Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:

All children 6 years of age or younger must be evaluated for lead exposure.

All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test *must* be obtained.
- If there are any "YES" or "DON'T KNOW" answers **and**
 - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
 - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
 - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Child's name _____ Today's date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.

RESPONSE

- | | Yes | No | Don't Know |
|--|-----|----|------------|
| 1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area? (see reverse side of page for high risk ZIP code area list) | Yes | No | Don't Know |
| 2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program?

***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed. | Yes | No | Don't Know |
| 3. Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978? | Yes | No | Don't Know |
| 5. Is this child a refugee, adoptee, or recent visitor of any foreign country? | Yes | No | Don't Know |
| 6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)? | Yes | No | Don't Know |
| 7. Does this child live with someone who has a job or a hobby that may involve lead (for example; jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)? | Yes | No | Don't Know |
| 8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)? | Yes | No | Don't Know |
| 10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? | Yes | No | Don't Know |

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.**

Fax: 217-557-1188 Phone: 866-909-3572

Signature of Doctor/Nurse

Date

**Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466**



Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams 62301 62320 62324 62339 62346 62348 62349 62365	Christian 62083 62510 62517 62540 62546 62555 62556 62557 62567 62570	DuPage 60519 Edgar 61917 61924 61932 61933 61940 61944 61949	Grundy 60437 60474 Hamilton 62817 62828 62829 62859 Hancock 61450 62311 62313 62316 62318 62321 62330 62334 62336 62354 62367 62373 62379 62380	Jefferson 62883 Jersey 62030 62063 Jo Daviess 61028 61075 61085 61087 Johnson 62908 62923 Kane 60120 60505 Kankakee 60901 60910 60917 60954 60969	Livingston 60420 60460 60920 60921 60929 60934 61311 61313 61333 61740 61741 61743 61769 61775 Logan 62512 62518 62519 62548 62543 62635 62643 62666 62671 Macon 62514 62521 62522 62523 62526 62537 62551 Macoupin 62009 62033 62069 62085 62088 62093 62626 62630 62640 62649 62672 62674 62685 62686 62690 Madison 62002 62048 62058 62060 62084 62090 62095 Marion None Marshall 61369 61377 61424 61537 61541 Mason 62617 62633 62644 62655 62664 62682	Massac 62953 McDonough 61411 61416 61420 61422 61438 61440 61470 61475 62374 McHenry 60034 McLean 61701 61720 61722 61724 61728 61730 61731 61737 61770 Menard 62642 62673 62688 Mercer 61231 61260 61263 61276 61465 61476 61486 Monroe None Montgomery 62015 62019 62032 62049 62051 62056 62075 62077 62089 62091 62094 62538 Morgan 62601 62628 62631 62692 62695 Moultrie 61937 Ogle 61007 61030 61047 61049 61054 61064 61091	Peoria 61451 61529 61539 61552 61602 61603 61604 61605 61606 Perry 62832 62997 Piatt 61813 61830 61839 61855 61929 61936 Pike 62312 62314 62323 62340 62343 62345 62352 62355 62356 62357 62361 62362 62363 62366 62370 Pope None Pulaski 62956 62963 62964 62976 62992 Putnam 61336 61340 61363 Randolph 62217 62242 62272 Richland 62419 62425 Rock Island 61201 61236 61239 61259 61265 61279 St. Clair 62201 62203 62204 62205 62220 62289	Saline 62930 62946 Sangamon 62625 62689 62703 Schuyler 61452 62319 62344 62624 62639 Scott 62621 62663 62694 Shelby 62438 62534 62553 Stark 61421 61426 61449 61479 61483 61491 Stephenson 61018 61032 61039 61044 61050 61060 61062 61067 61089 Tazewell 61564 61721 61734 Union 62905 62906 62920 62926 Vermilion 60932 60942 60960 60963 61810 61831 61832 61833 61844 61848 61857 61865 61870 61876 61883 Wabash 62410 62852 62863	Warren 61412 61417 61423 61435 61447 61453 61462 61473 61478 Washington 62214 62803 Wayne 62446 62823 62843 62886 Shelby 62438 62534 62553 White 62820 62821 62835 62844 62887 Whiteside 61037 61243 61251 61261 61270 61277 61283 Will 60432 60433 60436 Williamson 62921 62948 62949 62951 Winnebago 61077 61101 61102 61103 61104 Woodford 61516 61545 61570 61760
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