U. S. DEPARTMENT OF LABOR
JAMES J. DAVIS, Secretary
CHILDREN'S BUREAU
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STANDARDS FOR PHYSICIANS CONDUCTING CONFERENCES IN CHILD-HEALTH CENTERS

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LETTER OF TRANSMITTAL

U. S. Department of Labor,
Children's Bureau,
Washington, September 28, 1925.

Sir: I transmit herewith a report on Standards for Physicians Conducting Conferences in Child-Health Centers.

At a conference of State directors of maternity and infant hygiene the Children's Bureau was requested to appoint a committee to formulate standards which could be used by physicians in conducting child-health conferences. The standards were drafted by the pediatric advisory committee of the Children's Bureau, which consists of Dr. Richard Smith, of Boston, representing the American Pediatric Society; Dr. Julius Hess, of Chicago, representing the pediatric section of the American Medical Association; and Dr. Howard Childs Carpenter, of Philadelphia, representing the American Child Health Association, together with Dr. Martha M. Eliot, director of the child-hygiene division of the Children's Bureau. They have been submitted to and approved by Dr. Lawrence T. Royster, professor of pediatrics, University of Virginia; Dr. William Palmer Lucas, of the pediatric department, University of California Medical School; and Dr. J. H. Mason Knox, jr., director bureau of child hygiene, State department of health, Baltimore, Md.

Respectfully submitted.

Grace Abbott, *Chief.*

Hon. James J. Davis,
Secretary of Labor.

64006°—26†

STANDARDS FOR PHYSICIANS CONDUCTING CONFERENCES IN CHILD-HEALTH CENTERS

IMPORTANCE OF UNIFORM RECORDS

The following standards for physicians conducting conferences in child-health centers are proposed in an effort to bring about uniformity in the work being done for infants and preschool children in the various States which are working, through their child-hygiene divisions, in cooperation with the United States Children's Bureau. The value of the records kept in any State is much greater if the same standards of examination and record keeping are used by all physicians in that State. Such identity of standards will permit comparisons between the condition of children in one county or city and that of children in another. In the same way the value of comparison of the records kept by the different States would be increased if the standards used throughout the country were uniform. Uniform statistical records of children from all parts of the country would be of very great value.

GENERAL STANDARDS

1. The conferences must be limited to well babies or well children. Sick children must be referred to family physicians or dispensaries.
2. Complete physical examinations of all children must be made at their first visit to the center, and records must be kept by the physician.
3. Children with physical defects must be referred to the family physician with recommendations; if the family can not afford a private physician some arrangements should be made for free treatment at a dispensary. If a dispensary is not available some other provision for care should be made.
4. Examinations by specialists should be recommended through the family physician.
5. No medicine should be given by the conference physician.
6. Regularity in attendance on the part of the physician is of the utmost importance for a successful conference. If a physician is unable to be present a substitute must be provided. It is preferable that the same substitute should come to the center each time that the regular attending physician is absent.
7. Promptness is essential. The physician should be present at the hour of the opening of the center or at the time of the first appointment, if an appointment system is followed.

ATTENDANCE

GENERAL RULES

Mothers should be urged to bring infants under 1 year of age to the child-health center every week; they should bring infants between 1 and 2 years at least every two weeks, and preschool children every month.

Normal infants under 1 year should be weighed by the nurse every week, but if they gain weight steadily they need be seen by the physician only every four weeks. Any infant who does not gain regularly each week should be seen by the physician, as well as weighed, at each conference. Also during the period when formulas are being changed and during the weaning period it may be necessary for the infant to be seen more often.

REGULARITY

Regularity in children's attendance at the center depends on the quality of medical advice offered, the regularity and promptness of the physician, and the interest of both the physician and the nurse in each individual child.

APPOINTMENT SYSTEM

The physician will find that he can plan the conferences best and do the best work under an appointment system. The mothers will appreciate such a system, and the physician will also be able to plan his private activities to better advantage. Group appointments may be made; that is, three or four patients may be given appointments at 1 o'clock, three or four at half past 1, etc., so that the children will be brought at intervals throughout each conference.

CONDUCT OF THE CONFERENCE

The number of children seen by one physician during the conference at a center should be limited. One physician can not handle adequately more than 20 to 30 infants or 10 to 15 preschool children in one afternoon, the number seen depending on the number of physical examinations to be made. If more than this attend, a second physician should assist or a second conference be established. The allotted time for a conference should not exceed two and one-half hours.

Physicians should be aided during conference by the nurse or nutrition worker who has the home supervision of the children under her personal charge. Much help is obtained from her reports.

WEIGHING

Infants under 2 years of age should be weighed without clothes. Those attending the center for the first time should remain undressed until seen by the physician. Prolonged exposure should be avoided.

For preschool children it is more accurate to take weights without clothes and heights without shoes, but in some preschool conferences this can not be done. All children to be seen by the physician should be wholly undressed at each visit to the center.

HISTORY TAKING

The history outline for new children (see pp. 1 and 4 of outline) should be filled out by the nurse, or as much as possible by a lay assistant under the direction of the nurse, at the first conference attended. The section on personality and behavior should be checked by the physician. The physician should also review the rest of the history and make any necessary additions in the space allowed for remarks on the third page.

EXAMINATIONS

No child should be examined unless accompanied by the mother or some responsible friend or relative to whom recommendations can be made. Every child should have a complete physical examination at the first conference attended. Infants should have repeat examinations every *four months*. Preschool children should have them every six months and as much oftener as necessary.

ACTION ON DEFECTS

All defects should be noted by the physician and reported to the mother at his discretion. A complete written report should be sent to the physician whom the mother names as the family physician. If a physician can not be employed by the family, arrangements should be made by the nurse to have the necessary treatment given at a dispensary or free clinic, or other provisions may be made for free care. Defects must be remedied before a child can be expected to gain and be well.

DETERMINING THE NUTRITIONAL STATE

The state of a child's nutrition can be determined only by an examination of the child stripped and by comparison of the child's height and weight with the average standards set forth on the accompanying height-weight-age tables. Use of these tables alone, without observation of the amount of subcutaneous fat, the tone of the tissues and muscles, and the general appearance of the child, may give false impressions of the child's nutrition. The following height-weight-age tables give standards for average boys and girls from 1 month to 6 years of age. These tables may be used for children weighed without clothes. Having been based on average children, the tables are somewhat low for normal children. Any child falling 10 per cent below the average here given should probably be considered undernourished. Any child 20 per cent above the average may be too fat. Examination of children without their clothes will bring additional evidence to bear on the individual cases. Height-weight-age tables should never be used without an examination of the child.

Weight-height-age table for girls from birth to school age

Height (inches)	1 mo.	3 mos.	6 mos.	9 mos.	12 mos.	18 mos.	24 mos.	30 mos.	36 mos.	48 mos.	60 mos.	72 mos.
20	8											
21	9	10										
22	10	11										
23	11	12	13									
24	12	13	14	14								
25	13	14	15	15								
26		15	16	17	17							
27		16	17	18	18							
28			19	19	19	19						
29			19	20	20	20						
30			21	21	21	21	21					
31				22	22	23	23	23				
32					23	24	24	24	25			
33						25	25	25	26			
34						26	26	26	27			
35						29	29	29	29	29		
36							30	30	30	30	31	
37							31	31	31	31	32	
38								33	33	33	33	
39								34	34	34	34	34
40									35	36	36	36
41										37	37	37
42										39	39	39
43										40	41	41
44											42	42
45												45
46												47
47												50
48												52

Weight-height-age table for boys from birth to school age

Height (inches)	1 mo.	3 mos.	6 mos.	9 mos.	12 mos.	18 mos.	24 mos.	30 mos.	36 mos.	48 mos.	60 mos.	72 mos.
20	8											
21	9	10										
22	10	11										
23	11	12	13									
24	12	13	14									
25	13	14	15	16								
26		15	17	17	18							
27		16	18	18	19							
28			19	19	20	20						
29			20	21	21	21						
30			22	22	22	22	22					
31				23	23	23	23	24				
32				24	24	24	25	25				
33					26	26	26	26	26			
34						27	27	27	27			
35						29	29	29	29	29		
36							30	31	31	31		
37							32	32	32	32	32	
38								33	33	33	34	
39								35	35	35	35	
40									36	36	36	36
41										38	38	38
42										39	39	39
43										41	41	41
44											43	43
45											45	45
46												48
47												50
48												52
49												55

FEEDING RECOMMENDATIONS

For Infants.

It is important that the feeding of normal infants, whether breast fed or artificially fed, be supervised regularly, in order that serious disturbances may be prevented by remedying minor ones. Mothers who are nursing their infants often need simple advice quite as much as those whose infants are artificially fed. Feeding recommendations may be given for all well babies or those with minor digestive disturbances such as constipation or spitting up. The importance of breast feeding for infants can not be overemphasized. It is desirable that an infant be breast fed for eight or nine months. One substitute feeding after four months may be advisable. The following measures for the maintenance of the quantity and quality of breast milk must be stressed:

1. Regularity of feedings.
2. Complete emptying of the breasts either by the infant or by manual expression.[1]
3. An adequate diet for the mother. This includes 1 quart of milk, a leafy vegetable, a citrous fruit, and an egg daily.
4. Daily exercise for the mother out of doors in the sun, preferably during midday, or in very hot weather before 12 and after 3.
5. Both breasts should be given at each nursing period if one does not furnish sufficient milk for the baby's needs. This may be done by giving each breast for 10 minutes or one breast for 15 minutes and the second for 5 minutes. Alternate breasts must be given first at successive periods. It is important that the first breast be emptied before the second is given.

If the supply of breast milk is inadequate, complemental feedings after each breast feeding will tend to keep up the supply, whereas artificial feedings substituted for two or more feedings may tend to diminish the supply. One substitute feeding can usually be given without diminishing the supply of breast milk. Formulas may be recommended and the usual changes made as the child grows older.

When it becomes necessary to give artificial food to an infant, simple whole-milk modifications are usually satisfactory and can be made up easily by the mother. Formulas made from condensed milk and proprietary foods are unsuited to the needs of growing infants and frequently are dangerous. All milk for infants and young children should be boiled. Boiling kills all pathogenic bacteria and also makes the milk more digestible. Pasteurization, rightly done, kills pathogenic bacteria, but it does not increase the digestibility of the milk. Cod-liver oil should be recommended as an additional food for all babies over 1 month of age, whether breast fed or artificially fed, and should be continued for two years. On extremely hot days cod-liver oil may be omitted if the baby receives a sun bath. An infant 1 month of age can take ½ teaspoonful of cod-liver oil twice a day, an infant of 2 months 1 teaspoonful twice a day, and an infant of 3 months 1½ teaspoonfuls twice a day. Orange juice should also be given as an additional food to all artificially-fed babies. It may be given to breast-fed babies. An infant 1 month of age can take ½ ounce of orange juice daily. This should be

[1] Sedgwick, J. P.: "A study of breast feeding in the city of Minneapolis." Archives of Pediatrics, July, 1920, p. 442.

increased rapidly to 1 ounce daily if the infant is artificially fed. When it is impossible to obtain orange juice, tomato juice may be substituted in like amounts. For suggestions regarding simple whole-milk formulas see Infant Care, United States Children's Bureau Publication No. 8.

For Preschool Children.

Diet advice should be given for all preschool children, whether they are obese, well nourished, or undernourished. Eating habits, sleeping habits, play habits, and home discipline must be inquired into. Malnutrition and obesity are frequently traceable to bad habits. The nurse or nutrition worker can teach the mother to prepare the right foods. Help must also be given the mother in teaching her child good health habits. For diet outlines for preschool children see Child Care, United States Children's Bureau Publication No. 30. For proper habits and training see Child Management, United States Children's Bureau Publication No. 143.

SUN BATHS

It is important to teach mothers that all babies should be placed in the sun for a part of every sunny day. The rays of the sun should reach the skin directly, not through glass or clothing. The length of the sun bath should gradually be increased, beginning with 10 minutes on the arms and legs and increasing to 1 hour twice daily, if possible. The face also may be exposed if the head is turned so that the eyes are not directly toward the sun. In the spring, summer, and fall these sun baths may be given out of doors. In the winter it may be best to give the sun baths indoors in front of an open window. The child must lie in the patch of sunlight which comes through the *open* space.

RECORD KEEPING

Records must be kept for each infant or child. These should include the child's previous history, all physical examinations, notes on the feeding or diet recommended by the physician, and notes on home conditions observed by the nurse or nutrition worker. The notes made by the physician or nurse should be made on the same sheet, the order being chronological. Notes made by the nurse may be in red ink and those made by the physician in black ink so that they may be quickly differentiated. The nurse in charge of the conference should be responsible for the records. She should always keep a record of her instruction or advice to the mother about seeing her family physician, with the date of such instruction and a note as to whether the family physician was seen.

TERMINOLOGY

Where physical examinations are being made and records kept by a large number of different physicians it is of great importance that all the physicians should use the same terminology upon these records. If records are ultimately to be of statistical value, uniform terminology is essential. For instance, it has been found that in one State alone 35 different terms have been used to describe the tonsils. Simplified

INFANT AND PRESCHOOL CONFERENCE RECORD

NURSE'S OBSERVATIONS

Family No.

Date opened

Name Age yrs. mos. Sex M. F. Color W. B. Nationality

Guardian

Address 1. St. City Town State

2. St. City Town State

Family physician

Name

Address

Family	Name	Age	Sex	Health, or cause of death	Age at death
Father					
Mother					
Pregnancies 1					
2					
3					
4					
5					
6					
7					
8					

Birth history

Birth date Birth weight lbs. oz.

Birth condition: G. F. P. Injury. Malformation (spec.)

Full term Premature mos.

Delivery spon. difficult operative (spec.)

Physician Midwife Neither.

Eye prophylaxis: Yes. No.

Birth certificate received: Yes. No.

Prenatal care of mother: No. Yes. for mos. Wass. Pos. Neg.

Economic status of family: Good. Fair. Poor.

NEONATAL PERIOD—NURSE'S RECORD

Date	Home=H Conf.=C	Temp.	Weight	Cord: O=Off B=Bleeding I=Inflamed	Eyes: R=Red S=Swollen D=Discharge	Skin: R=Rash D=Dry J=Jaundice	Hemorrhages	Cyanosis	Convulsions	Snuffles	Stools: Give No. daily N=Normal D=Diarrhea B=Blood	Feeding: Breast fed	Formulas—Specify	Comp.	Substitute	Amount	No. of feedings	Interval	Vomiting	Nurse's initials

INFANCY AND PRESCHOOL RECORD

Date Previous illness

Measles N. Y. yrs. Rheumatism N. Y. yrs.

Pertussis N. Y. yrs. Digestive dis. N. Y. mos.

Diphtheria N. Y. yrs. (spec.)

Scarlet fever N. Y. yrs. Respiratory dis. N. Y. yrs.

Sore throat N. Y. yrs. (spec.)

Development: First tooth at mos. Sat up at mos. Walked at mos. Talked at mos.

Date	Test	Result	Done by	Date	Test	Result	Done by
	Wass.				Schick		
	Tuberculin				T. A. T.		
	Vaccin. (sm.)						
	Blood						
	Urine						

HABITS (check at each examination)

Date	Sleep: Alone	Windows open	Goes to bed—	Gets up at—	Sleep: G. F. P.	Rest during day	Exercise: Too little=L Enough=E Too much=M	Sun: Hours outdoor sun	Hygiene: No. baths weekly	Hands washed before eating	Teeth brushed twice daily	Daily stool	Cathartics given	Food: Regular meals	Eats between meals	Fussy about food	Appetite: G. F. P.	Intelligence: Superior	Average	Fair	Personality traits [1]: Unresponsive (seclusive)	Suggestible—Imitative	Timid—Fearful	Forward—Seeking attention	Indifferent to praise or blame	Inferiority feelings	Undesirable habits: Tantrums	Crying spells	Night terrors	Enuresis	Masturbation	Speech defect	Thumb sucking	Other: Obedience: G. F. P.	Self-control: G. F. P.	Parental management: G. F. P.

[1] See text for further definitions.

PHYSICAL EXAMINATIONS

Date					
GENERAL APPEARANCE:					
Facial expression (spec.)	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
Color of skin and M. M.	Good. Pale.	Good. Pale.	Good. Pale.	Good. Pale.	Good. Pale.
MUSCULAR DEVELOPMENT★	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
Subcutaneous fat★	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
SKELETAL DEVELOPMENT:					
Type: Thin, intermed., stocky (spec.)					
Posture: A, B, C, D (spec.)					
Spine, spec. Lord. Scol. Kyph.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
EVIDENCES OF RICKETS★	None.	None.	None.	None.	None.
HEAD: Asymmetrical★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Fontanelle open	N. Y. ____cm.	N. Y. ____cm.	N. Y. ____cm.	N. Y. ____cm.	N. Y. ____cm.
Craniotabes★	N. Y.	N. Y.	N. Y	N. Y.	N. Y.
Cranial bosses★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
CHEST: Asymmetrical★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Flat. Pigeon. Funnel (spec.)	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Beaded ribs★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Harrison's groove★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
EXTREMITIES: Epiphyses enl.★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Bowlegs★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Knock-knees★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Feet pronated★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
SKIN: Dry	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Rash (describe)	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
LYMPH NODES: Enlarged★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Spec. Cerv. Epi. Ax. Ingu.					
EYES: Strabismus	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Other defects					
EARS: Discharge	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Hearing★	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
Drums					
NOSE: Obstruction	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Discharge (describe)	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Adenoids	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Turbinates enl.★	N. Y.	N. Y.	N. Y.	N. Y	N. Y.
Septum deviated	N. Y. Rt. Lt.	N. Y. Rt. Lt.	N. Y. Rt. Lt.	N. Y. Rt. Lt.	N. Y. Rt. Lt.
THROAT: Tonsils enlarged★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Tonsils diseased★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
TEETH: Clean. Number	N. Y. No.	N. Y. No.	N. Y. No.	N. Y. No.	N. Y. No.
(X=carious; A=abscess; F=filled; O=out.	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3
Indicate condition over no. of tooth.)	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2 3 4 5	5 4 3 2 1 1 2
Occlusion★					
TONGUE TIE; PALATE DEFECT (spec.)	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
GUMS: Bleeding; inflammation	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
HEART (if abnormal make note on p. 3)	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
LUNGS (if abnormal make note on p. 3)	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
ABDOMEN: Muscles★	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.	Nor. Abn.
Liver enlarged★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Spleen enlarged★	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Umbilicus infected	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
HERNIA: Umb. Ingu. Fem. (spec.)★	N. Y	N. Y.	N. Y.	N. Y.	N. Y.
GENITALS: Testes desc.	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Phimosis	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Circumcised	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Hydrocele	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Vaginal discharge	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
NERVOUS SYSTEM: Chvostek	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Knee jerks	Pres. Abs.	Pres. Abs.	Pres. Abs.	Pres. Abs.	Pres. Abs.
Spasticity	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
Paralyses (describe)	N. Y.	N. Y.	N. Y.	N. Y.	N. Y.
MENTALITY:	Nor. Retarded.	Nor. Retarded.	Nor. Retarded.	Nor. Retarded.	Nor. Retarded.
Examined by					

Check all items at each examination (/). N=No. Y=Yes. Nor.=Normal. Abn.=Abnormal.

★ Indicate degree of impairment as follows: X=Slight abnormality

	Date	POSITIVE FINDINGS	Recommendations by Physicians and Additional Laboratory Examinations
Nor. Abn.		**HEART** (if abnormal):	
Good. Pale.		Size ------ cm. fr. M. S. L. in ------ i. s. (left).	
Nor. Abn.		------ cm. fr. M. S. L. in ------ i. s. (rt.).	
Nor. Abn.		Apex in ------ i. s. ------ cm. fr. M. S. L.	
		Sounds: Clear. Soft. Sharp.	
		Murmurs: Systolic. Diastolic. Presys.	
		At apex. Pulmonic. Aortic.	
		Rhythm: Reg. Irreg. B. P.	
		LUNGS (if abnormal): Percussion.	
		Auscultation.	
or. Abn.		D'Espines sign to ------ Dorsal vert.	
one.			
N. Y.		**HEART** (if abnormal):	
Y. ----cm.		Size ------ cm. fr. M. S. L. in ------ i. s. (left).	
N. Y.		------ cm. fr. M. S. L. in ------ i. s. (rt.).	
N. Y.		Apex in ------ i. s. ------ cm. fr. M. S. L.	
. Y.		Sounds: Clear. Soft. Sharp.	
N. Y.		Murmurs: Systolic. Diastolic. Presys.	
N. Y.		At apex. Pulmonic. Aortic.	
. Y.		Rhythm: Reg. Irreg. B. P.	
N. Y.		**LUNGS** (if abnormal): Percussion.	
N. Y.		Auscultation.	
N. Y.		D'Espines sign to ------ Dorsal vert	
N. Y.		**HEART** (if abnormal):	
N. Y.		Size ------ cm. fr. M. S. L. in ------ i. s. (left).	
. Y.		------ cm. fr. M. S. L. in ------ i . s. (rt.).	
. Y.		Apex in ------ i. s. ------ cm. fr. M. S. L.	
		Sounds: Clear. Soft. Sharp.	
. Y.		Murmurs: Systolic. Diastolic. Presys.	
		At apex. Pulmonic. Aortic.	
. Y.		Rhythm: Reg. Irreg. B. P.	
		LUNGS (if abnormal): Percussion.	
. Y.		Auscultation.	
or. Abn.		D'Espines sign to ------ Dorsal vert.	
. Y.		**HEART** (if abnormal):	
. Y.		Size ------ cm fr. M. S. L. in ------ i. s. (left).	
Y.		------ cm. fr. M. S. L. in ------ i. s. (rt.).	
Y.		Apex in ------ i. s. ------ cm. fr. M S. L.	
Y. Rt. Lt.		Sounds: Clear. Soft Sharp.	
Y.		Murmurs: Systolic. Diastolic. Presys.	
Y.		At apex. Pulmonic. Aortic.	
Y. No.		Rhythm: Reg. Irreg. B. P.	
4 3 2 1 1 2 3 4 5		**LUNGS** (if abnormal): Percussion.	
4 3 2 1 1 2 3 4 5		Auscultation.	
		D'Espines sign to ------ Dorsal vert.	
or. Abn.		**HEART** (if abnormal):	
Y.		Size ------ cm. fr. M. S. L. in ------ i. s. (left).	
bn.		------ cm. fr. M. S. L. in ------ i. s. (rt.).	
n.		Apex in ------ i. s. ------ cm. fr. M. S. L.	
n.		Sounds: Clear. Soft. Sharp.	
		Murmurs: Systolic. Diastolic. Presys.	
		At apex. Pulmonic. Aortic.	
		Rhythm: Reg. Irreg. B. P.	
		LUNGS (if abnormal): Percuss on.	
		Auscultation.	
		D'Espines sign to ------ Dorsal vert.	
N. Y.		**HEART** (if abnormal):	
N. Y.		Size ------ cm. fr. M. S. L. in ------ i. s. (left).	
N. Y		------ cm. fr. M. S. L. in ------ i. s. (rt.).	
N. Y.		Apex in ------ i. s. ------ cm. fr. M. S. L.	
Y.		Sounds: Clear. Soft. Sharp.	
N. Y.		Murmurs: Systolic. Diastolic. Presys.	
N. Y.		At apex. Pulmonic. Aortic.	
Pres. Abs.		Rhythm: Reg. Irreg. B. P.	
N. Y.		**LUNGS** (if abnormal): Percussion.	
N. Y.		Auscultation.	
Nor. Retarded.		D'Espines sign to ------ Dorsal vert.	

not requiring medical attention. 2X=Moderate abnormality requiring further examination and follow-up care. 3X=Marked abnormality requiring immediate medical attention.

FEEDING HISTORY (Check at each e: kamination)

Present														Past
Date	Age in mos.	Breast fed	Artificially fed	Mixed feeding	No. of feedings	Amount	Interval	Regular N. Y.	How taken G. F. P.	Satisfied N. Y.	Formulas [W. M.=Whole milk; W.=boiled water. Indicate type of carbohydrate C. S., D. M., Lac., Karo, B. F., etc. Proprietary food=P. F. Cond. milk=Cd. M.]	Whole milk, Amt. daily	Orange juice or fruit	Cod-liver oil	Cereal	Green vegetable daily	Egg	Meat	Tea or coffee	Excessive carbohydrate	Breast fed: wks. mos. Mixed feeding: wks. mos. Weaned at: mos. Artificial formula at mos. (Spec.) Recent illnesses with age:

PHYSICIAN'S AND NURSE'S FOLLOW-UP NOTES

Date	Age in mos.	Home—Conf.	Weight	Height	Av. wt. for ht.	Remarks—Formulas, etc.

[Insert sheet--face]

PHYSICIAN'S AND NURSE'S FOLLOW-UP NOTES—Continued

Date	Age in mos.	Home—Conf.	Weight	Height	Av. wt. for ht.	Remarks—Formulas, etc.

[Insert sheet—reverse]

PHYSICIAN'S AND NURSE'S FOLLOW-UP NOTES—Continued

Date	Age in mos.	Home—Conf.	Weight	Height	Av. wt. for ht.	Remarks—Formulas, etc.

terminology is suggested on the outline for physical examination which follows. With such uniform terminology valuable studies can be made by comparing records from different counties of the same State or by comparing records from different States.

OUTLINE FOR HISTORY AND PHYSICAL EXAMINATION OF INFANTS AND PRESCHOOL CHILDREN [1]

The accompanying outline has been compiled after study of the forms used by a large number of States, ideas from many of which have been adopted. The outline is intended to be printed on a sheet 11 by 8½ inches in size.

History.

The first page and the upper third of the fourth page of the outline cover the history of the infant or preschool child. This history should be filled in by the nurse or by a lay assistant under her direction. Every item applicable to the infant or preschool child should be checked. The section on the neonatal period is to be filled in at each visit by the nurse who cares for the infant at this time.

The section on intelligence, personality traits, and habits should be checked by the physician. If the history is being taken for an infant some items under these sections will not be applicable. The items under intelligence and personality traits have been selected from a list suggested for this pamphlet by Dr. D. A. Thom, director of the habit clinics of Boston and director of the division of mental hygiene in the department of mental diseases of Massachusetts. They are included in the outline to indicate to the examining physician some of the traits of early childhood which have a direct bearing on the development of the mental life of the child and adult. The list is not intended to be complete. Other traits also suggested by Doctor Thom which might be considered are the following: Desire for approbation as well as attention; vindictiveness, maliciousness, and grudge holding; purposefulness—that is, interest in the end desired and not the means; pleasure seeking—that is, interest in the means of attaining an end; sullenness, resentfulness; whining, discontent; feelings of inadequacy because of physical handicaps. When submitting the list of personality traits Doctor Thom made the following comments:

"To the suggestible and imitative child environment takes on an added importance.

"Fears in children may be expressed simply in a marked general timidity or may be crystallized in the child's definite phobia.

"A child may feel inferior and inadequate to meet the everyday problems. He may manifest his inferiority complex in several ways; i. e., physical illness, delinquency, paranoid tendencies or by becoming a dreamer.

"The pleasure seekers as opposed to the purposeful find satisfaction only in the means, whereas the purposeful child works toward a definite end."

For further suggestions along these lines see Child Management, United States Children's Bureau Publication No. 143 (a pamphlet

[1] These forms may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C.

for mothers) and Habit Clinics for the Child of Preschool Age, United States Children's Bureau Publication No. 135.

The child's habits and his feeding history should be rechecked at each physical examination in order that the history may be kept up to date. Spaces are provided for the six physical examinations. Illness occurring after the record has been started should be recorded on page 4 in the space provided.

Physical Examination.

The second and third pages of the outline are for the use of the physician. Headings for the physical examination are given in the left-hand column. These headings cover a simple routine examination. Symbols are arranged in each of the six parallel columns so that a nurse or lay assistant can check each item under the physician's direction. Much of the physician's time can be saved if his examination follows the outline so that someone else can check it as he proceeds. All items should be checked. The terminology suggested under the headings or in the footnotes should be used in each examination. The degree of impairment of all starred items should be indicated as follows:

x—Slight abnormality not sufficient to be called to the attention of the parent nor to warrant further medical attention at the time of examination.
2x—Moderate abnormality requiring further medical examination and follow-up care.
3x—Marked abnormality requiring immediate medical attention and follow-up.

This terminology corresponds in part with that recommended by the committee on school health problems of the American Public Health Association in its instructions for the classification of physical defects. All *positive findings and defects* should be noted, and described if necessary, in the spaces provided on page 3. One space is provided for each examination. When the defect has been removed or positive findings have disappeared the original notation should be underlined (preferably with red ink) and the date of removal or return to normal added. Any additional findings not allowed for under the printed headings should be described in the spaces on page 3.

The following items should be noted in connection with the physical examination:

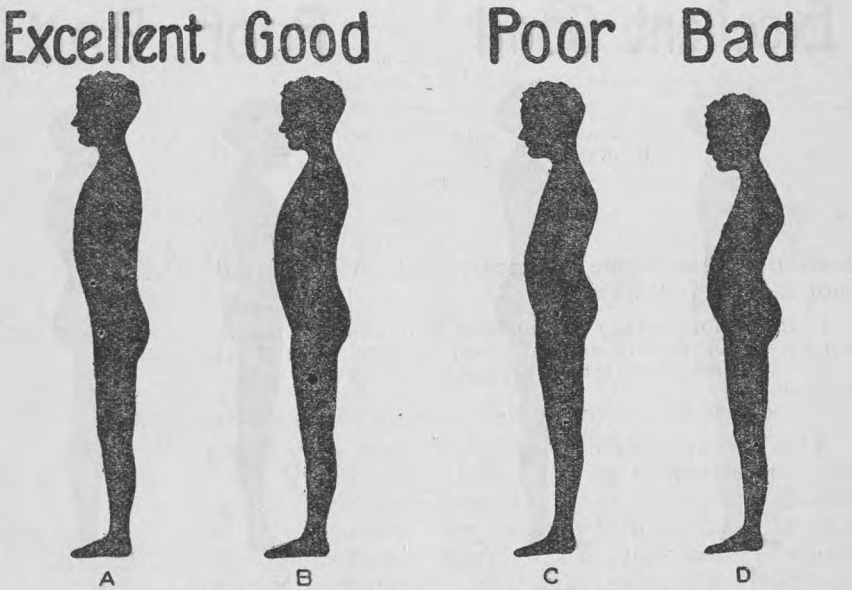
Posture.—The posture of preschool children may be indicated A, B, C, D, according to the standards shown in the accompanying charts. The skeletal type may also be indicated as thin, intermediate, or stocky. A set of six charts showing these standards and types can be obtained from the United States Children's Bureau. They should be placed in a conspicuous position in the preschool conference room so that the physician may refer to them constantly. The mother's interest in her child's posture should be aroused.

Nose and throat.—1. The presence of adenoids may be determined by the following: (*a*) Evidence of nasal obstruction—mouth breathing; (*b*) enlarged posterior cervical glands; (*c*) appearance of throat—presence of adenoid tissue on posterior pharyngeal wall and restriction of motion of soft palate; (*d*) facial expression—the so-called "adenoid facies."

2. The size of the inferior turbinates should be noted and any deviation of the septum toward the right or left. In the preschool

POSTURE STANDARDS

Intermediate-Type Boys



EXCELLENT POSTURE	GOOD POSTURE	POOR POSTURE	BAD POSTURE
1. Head up-chin in (Head balanced above shoulders, hips, and ankles)	1. Head slightly forward.	1. Head forward.	1. Head markedly forward.
2. Chest up (Breast bone the part of body farthest forward.)	2. Chest slightly lowered.	2. Chest flat.	2. Chest depressed (Sunken)
3. Lower abdomen in, and flat.	3. Lower abdomen in (but not flat)	3. Abdomen relaxed (Part of body farthest forward.)	3. Abdomen completely relaxed and protuberant.
4. Back curves within normal limits.	4. Back curves slightly increased.	4. Back curves exaggerated.	4. Back curves extremely exaggerated.

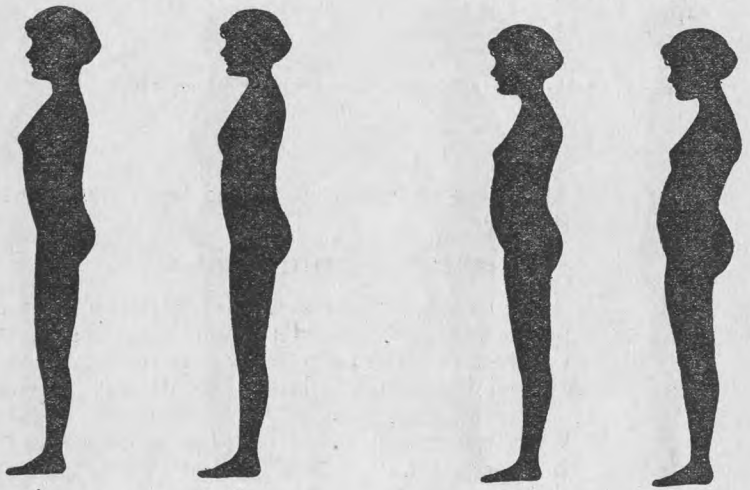
Children's Bureau, United States Department of Labor, Washington, D.C., 1925.

[The figures shown in these posture charts are obviously those of children of school age, but they will assist the physician in classifying the posture of the preschool children according to page 2 of the form. The set of six charts was prepared by the Children's Bureau for use in posture clinics, child-health centers, and schools, and may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C., at 50 cents per set.]

POSTURE STANDARDS

Intermediate-Type Girls

Excellent Good Poor Bad



A B C D

EXCELLENT POSTURE	GOOD POSTURE	POOR POSTURE	BAD POSTURE
1. Head up-chin in. (Head balanced above shoulders, hips, and ankles)	1. Head slightly forward.	1. Head forward.	1. Head markedly forward.
2. Chest up (Breast bone the part of body farthest forward.)	2. Chest slightly lowered.	2. Chest flat.	2. Chest depressed (sunken)
3. Lower abdomen in, and flat.	3. Lower abdomen in (but not flat)	3. Abdomen relaxed (Part of body farthest forward.)	3. Abdomen completely relaxed and protuberant.
4. Back curves within normal limits.	4. Back curves slightly increased.	4. Back curves exaggerated.	4. Back curves extremely exaggerated.

Children's Bureau, United States Department of Labor, Washington, D.C., 1925.

Surname Father's name

[Lip of folder.]

FAMILY FOLDER

City State Family No.

Village Date opened

Township

Date	Address	Directions	Housing	Owned	Rented	Rent per mo.	Sanitation	Economic status	Milk supply	Family physician	Religion
	1		G. F. P.				G. F. P.	G. F. P.			
	2		G. F. P.				G. F. P.	G. F. P.			
	3		G. F. P.				G. F. P.	G. F. P.			
	4		G. F. P.				G. F. P.	G. F. P.			
	5		G. F. P.				G. F. P.	G. F. P.			

		Year of birth	Country of birth	Health or cause of death	Ins. Co.	Occupation	Speaks Eng.	Reads Eng.	Remarks
	Father								
	Mother								
★	Pregnancies								
	1								
	2								
	3								
	4								
	5								
	6								
	7								
	8								
	9								
	10								

Others in household	Kinship	Other relatives	Addresses	Kinship	
		1			
		2			
		3			

Other agencies interested:

ADDITIONAL SOCIAL DATA AND REMARKS

Date		Date	

★ Check in this space all individuals having records in folder. U. S. Department of Labor, Children's Bureau. C. B. 105. 64006°—26†. (Face p. 10.)

child, however, enlarged turbinates or deviated septum are not indications for operations. The enlarged turbinate may indicate a chronic ethmoid sinusitis.

Heart.—If the heart is normal check "normal." If it is abnormal check "abnormal" and fill in the details for which space is given on page 3.

Lungs.—Check "normal" or "abnormal." If they are abnormal fill in the details for which space is given on page 3.

Follow-Up Notes.

The fourth page is to be used by both physicians and nurses for follow-up notes whenever the child is seen, whether at the center or at home. Diet advice and formulas should be noted by the physician at each conference which the child attends. Help and advice given by the nurse at home visits must be recorded so that the physician may see at a glance what has taken place since the child's last appearance at a conference at the center. These notes should be kept chronologically. An insert sheet ruled in the same manner as the lower two-thirds of page 4 should be provided for a continuation of such follow-up notes.

REPORT TO MOTHERS

It is advisable to give the mother a written report of the child's condition. It should contain the child's name, age, height, weight, state of nutrition (whether obese, normal, or undernourished), and of the examining physician has so advised, mention of defects that may be present. The average weight for the child's height may also be given. A written report which can be taken home will be appreciated by the parents and will help to stimulate interest in improving the child's condition.

REPORT TO PHYSICIANS

A complete detailed report of the physical findings should also be sent to the family physician, and the mother should be told that such a report will be sent. It is important that a form be available for this purpose and that it be filled out by the examining physician as a matter of routine. If an examination by a specialist is necessary, this fact should be stated to the mother, but the recommendation must be made through the family physician.

FAMILY FOLDER[2]

A form for a "family folder" is shown opposite page 10. The folder should be approximately 9 by 11½ inches in order to hold the history and physical-examination outline, which is 8½ by 11 inches. Suggestions on such items as housing, sanitation, and milk supply are included on this form, and space is left for any social data which apply to the whole family or to any one member. Both the family surname and the father's first name should be given on the tab of the folder so as to facilitate identification of families having the same surname.

[2] These folders, on manila paper, may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C.