FORM 2C: Health Plan Implementation for CHILD HEALTH (Ages 12 mos-5 years)

2C

Part 1: HEALTH RISK ASSESSMENT & KEY HEALTH MESSAGES (Indicate Y, if 'yes'; N if 'no')

C1 Has your child been fully immunized against common childhood diseases, which are preventable, before his/her 1st birthday?

Fully immunized means the child received the ff: BCG, HepaB1,2,3; OPV1,2,3; DPT1,2,3; measles before his/her 1st birthday

(If Yes, check the immunization card of the child to see if all immunizations were given. If No, deliver Message for C1 then go to C2)

Message for C1

- Complete your child's immunization [tuberculosis (BCG), diphtheria, tetanus and whooping cough (DPT); polio (OPV), Hepatitis B and measles] to protect him/her from infectious diseases that may lead to permanent disability or death
- Free vaccines are available in your health center
- Bring with you ECCD or *Booklet ni Nanay* at ni Baby during immunization

C2 . Has your child received the following in the last 6 months? (please check)

- ☐ Vitamin A supplementation
- ☐ Deworming tablets

(*Deliver Message for C2 then go to C3*)

Message for C2

- Your baby must receive Vitamin A at 6-months old. Do this every 6 months until 5 years old. Vitamin A increases your baby's resistance to infectious diseases and helps prevent blindness.
- Deworming tablets help prevent intestinal worms. It impairs healthy nutrition, reduces appetite and leads to mal-absorption of nutrients that cause stunting, under-nutrition and anemia. Give your child deworming tablets at 1 year old. Do this every 6 months.

C3. Does your child have any of the following signs? *(please check)*

- ☐ Cough
- ☐ Diarrhea (soft stools at least 3 times a day)
- ☐ Fever
- ☐ Swelling of hands and feet
- ☐ Passing of intestinal worms
- ☐ Convulsions
- ☐ Poorly or unable to eat or drink
- ☐ Vomit everything
- ☐ Fast or difficulty in breathing
- ☐ Very sleepy or unconcious

(Deliver Message for C3 then go to Part 2)

Message for C3

- Bring your child to a health provider immediately
- Bring Form 2C, your PhilHealth card and Member Data Record (MDR)

*For more information, see **Family Health Guide Health, A. Health Messages. Caring for Infant and Child**, p. 8

Part 2: GENERAL INFORMATION (to be filled out with the help of the CHT partner)

Name of Respondent(Last name, first name, mother's maiden name)	NHTS HH ID: □□□□□□□□□–□□□□–□□□□
Name of Child(Last name, first name, mother's maiden name)	Date of Birth of Child (mm/dd/yy):
Name of CHT partner (Last name, first name, mother's maiden name)	Date of Visit when Health Plan was developed (mm/dd/yy):

Part 3: HEALTH PLAN (to be filled out with the help of the CHT partner)

3.1 Plan for **REGULAR** Cases

Health Goal	Referral Provider/s (name and address) (use the list of health providers in the Family Health Guide)	Date of planned visit (mo/day/year)
☐ To have my child completely immunized		
☐ To bring my child to the health facility for Vitamin A and deworming		
☐ To bring my child to a health facility for consultation and treatment		
☐ Others		

3.2 Plan for **EMERGENCY** Cases

Reasons for Emergency Referral	Emergency transport providers **(name and contact no.)**	Health Service Providers **(name and address)** Refer to List of Health Providers
☐ Consultation for immediate assessment and management of danger signs		

I/we understand the health risks and needs of our family and I/we have decided to develop this health plan.

_____
(Name and signature of respondent)

Part 4: ACTIONS TAKEN (to be filled out by the midwife, nurse or doctor)
(Please accomplish/update the Immunization Schedule in the **Mother and Child Book)**

Name and address of health provider:

Services provided: (specify vaccines and schedule, example: measles, Vitamin A, deworming tablet)	Date of consultation (mm/dd/yy): Schedule of next check-up(mm/dd/yy):

Instruction of the provider:

Part 5: Service Utilization and Monitoring Form for CHILD HEALTH				
Date of consultation (month/day/yr)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mo/day/yr)

Part 5: Service Utilization and Monitoring Form for CHILD HEALTH				
Date of consultation (month/day/yr)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mo/day/yr)