2yr.

Child's Name: ____________________ Date of birth: ______________
Date Form Completed: ________ Name of Person Completing Form: ____________

# M-CHAT Questionnaire:

Please fill out the following about how your child usually is. Please try to answer every question.
If the behavior is rare (e.g. you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc? Circle One: No Yes
2. Does your child take an interest in other children? Circle One: No Yes
3. Does your child like climbing on things, such as up stairs? Circle One: No Yes
4. Does your child enjoy playing pee-a-boo/hide-and-seek? Circle One: No Yes
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? Circle One: No Yes
6. Does your child ever use his/her index finger to point/to ask for something? Circle One: No Yes
7. Does your child ever use his/her index finger to point/to indicate interest in something? Circle One: No Yes
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them? Circle One: No Yes
9. Does your child ever bring objects over to you (parent) to show you something? Circle One: No Yes
10. Does your child look you in the eye for more than a second or two? Circle One: No Yes
11. Does your child ever seem oversensitive to noise? (e.g. plugging ears) Circle One: No Yes
12. Does your child smile in response to your face or your smile? Circle One: No Yes
13. Does your child imitate you? (e.g., you make a face-will your child imitate you?) Circle One: No Yes
14. Does your child respond to his/her name when you call? Circle One: No Yes
15. If you point at a toy across the room, does your child look at it? Circle One: No Yes
16. Does your child walk? Circle One: No Yes
17. Does your child look at things you are looking at? Circle One: No Yes
18. Does your child make unusual finger movements near his/her face? Circle One: No Yes
19. Does your child try to attract your attention to his/her own activity? Circle One: No Yes
20. Have you ever wondered if your child is deaf? Circle One: No Yes
21. Does your child understand what people say? Circle One: No Yes
22. Does your child sometimes stare at nothing or wander with no purpose? Circle One: No Yes
23. Does your child look at your face to check your reaction when faced with something unfamiliar? Circle One: No Yes

Please list any concerns about your child's learning, development, and/or behavior.

**This form must be completed at 18 months & 24 months of age.**

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**Child's Name:**__________________________ **Date of Birth:**____________

*Division of Public Health,*
*Prevention Services Branch*
*Tuberculosis Program*
*404-657-2634 fax: 404-463-3460*
*http://health.state.ga.us/programs/tb*

# Tuberculosis (TB) Risk Assessment

Child Health Services

Circle Yes or No.

| | | |
|---|---|---|
| 1. Is the child in close contact to a person sick with active TB disease? * | Yes | No |
| 2. Does the child have or is at risk to have HIV? | Yes | No |
| 3. Was the child or the child's parent born outside the US? | Yes | No |
| 4. Is the child exposed to a person in jail or a person who has been in jail in the past five years? | Yes | No |
| 5. Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home? | Yes | No |
| 6. Is the child exposed to drug users or migrant farm workers? | Yes | No |
| 7. Does the child have a health problem that lowers the immune system? | Yes | No |
| 8. Does the child live in a community that has a high risk for TB? | Yes | No |
| 9. Has the child traveled to or had a visitor from any foreign country since the last visit? | Yes | No |
| 10. 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?* | Yes | No |

** Call the Health Department*

*Any '**yes**' answer means the child is High Risk and should have a Mantoux TB skin test. The test should be read by a Health Professional.*

**For your child's health, this form is required to be completed at the following visits:**

DPH06/057W

**1 month** **6 month** **12 month** **18 month**

Rev. 08.2006

Child's Name:______________________ Date of Birth:__________

Georgia Department of Human Resources (DHR)
Division of Public Health

Georgia Department of Human Resources
Georgia Childhood Lead Poisoning Prevention Program
Lead Risk Assessment Questionnaire

1. Does your child live in or often visit a house that may have been built before 1978?
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?
3. Does your child live with or often visit another child that has an elevated blood lead level?
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
5. Does your child chew on or eat non-food items like paint chips or dirt
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
7. Does your child receive medicines such as *greta, azarcon, kohl, or pay-loo-ah*?

When using the questionnaire, blood lead tests should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

**For your child's health, this form is required to be completed at the following visits:**

**6 month** **9 month** **18 month**

**3 year** **4 year** **5 year** **6 year**

2 Peachtree Street NW • 15th Floor • Atlanta, Georgia 30303-3142
404-657-2700 • FAX: 404-657-2715
http://health.state.ga.us