

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

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)

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)

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 unconscious

(Deliver Message for C3 then go to Part 2)

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

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.

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)
<input type="checkbox"/> To have my child completely immunized		
<input type="checkbox"/> To bring my child to the health facility for Vitamin A and deworming		
<input type="checkbox"/> To bring my child to a health facility for consultation and treatment		
<input type="checkbox"/> 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
<input type="checkbox"/> 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:

