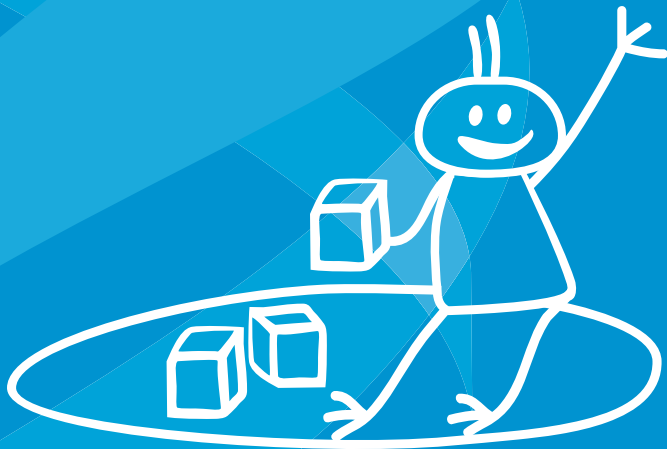


My first year (0-12 months)

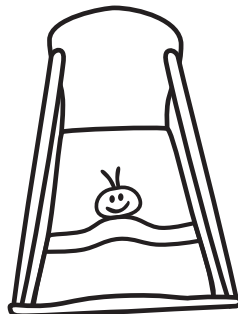


What I need

Some tips for caring for your baby.

<p>Sleep and settling</p>	<p>Babies vary a lot in how much they sleep</p> <ul style="list-style-type: none"> > Most babies wake in the night and young babies may wake several times for feeds > Your baby will give signs such as grimacing, eye rubbing, yawning, grizzling when they are tired, need to settle or sleep > Babies cry as part of normal development and this seems to happen more around 8 weeks of age. By 12 weeks they will start to cry less > Your crying baby needs comfort. Some babies go on crying even if you try to comfort them – but they will know that you are trying to help them > If your baby is unsettled, seek help. You could call the Parent Helpline for support and more ideas 1300 364 100 > For the first 6-12 months, the safest place for your baby to sleep is in their cot in your room to reduce the risk of Sudden Infant Death Syndrome. Visit the SIDS and Kids website www.sidsandkids.org
<p>Feeding</p>	<p>Your baby grows best when fed well</p> <ul style="list-style-type: none"> > Breastmilk is the best source of nutrition for your baby. Every extra month you can feed them breastmilk is a bonus for their health. Otherwise, the only safe alternative is infant formula > Most new babies will breastfeed between 8 to 12 times each day, but as they get older this will decrease > For good nutrition babies need solids from 6 months. As your baby gets older try different types and textures of foods > Always watch your baby when they are eating. Visit www.cyh.com and look up <i>choking</i> for information on safe eating for children under 4 years of age

<p>Safety</p>	<p>Babies need their parents to keep them safe. Newborns need to be handled with care, their head supported. <i>Never shake a baby.</i></p> <ul style="list-style-type: none">> Whenever you put your baby down to sleep make sure they are:<ul style="list-style-type: none">> on their back (never on the front or side), with their head and face uncovered and their feet at the bottom of the cot> in a cot that meets Australian Standards without quilts, doonas, duvets, pillows, cot bumpers, sheep skins and soft toys> not exposed to tobacco smoke> in a cot away from blind cords and other hazards with bedclothes tucked in securely or use a baby 'sleeping bag' that is the right weight for the season and fits the neck firmly> in the same room as the parents for the first 6-12 months> Use a correctly fitted capsule/car seat on every car trip – visit www.cyh.com and look up <i>Car safety restraints</i> to see the laws> Protect your baby from burns and scalds from things like hot water, hot drinks and the sun> If breastfeeding, not drinking alcohol is the safest option for your baby> One of the best things you can do is quit smoking. This will improve both your health and your baby's health. If you smoke near your baby, your baby smokes too. This is called passive smoking and increases your baby's chances of getting ill. For help to quit smoking call the Quitline on 137 848 <p>For more safety information visit www.kidsafe.com.au or call 08 8161 6318</p>
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Teeth	<p>Your baby's teeth are important</p> <ul style="list-style-type: none"> > Clean your baby's teeth when they appear. Use a soft toothbrush or cloth and avoid toothpaste until 18 months > Only use formula or water in the bottle. Avoid cordial, fruit juice and fizzy drinks > If you are bottle feeding, do not put your baby to bed with a bottle > From 6 months your baby can have tap water from a cup > Clean your baby's dummy under running water, not in your mouth. Germs from your mouth can be transferred to baby. Avoid sharing a spoon with your baby <p>For more information go to www.cyh.com and look for <i>Teeth – dental care for children</i> or call South Australian Dental Service on 08 8222 8222</p>
You and your baby	<p>Babies' brains develop best when you are there to care and respond to their emotional needs</p> <ul style="list-style-type: none"> > Babies communicate what they want by sounds and movements > Responding to your baby helps them to develop trust and security. This doesn't mean you are spoiling them > Babies have times where they develop faster and may be unsettled > Young babies need gentle play, look at them to see if they are enjoying it > Share the parenting. Dads can get involved in play, bathing and changing. Other family members can help too
Immunisation	<p>Important immunisations are due at birth, then 2, 4, 6 and 12 months of age</p> <ul style="list-style-type: none"> > Details are included on the immunisation schedule in the immunisation section of this record > For more information call 8226 7177 or 1300 364 100 or visit www.immunise.health.gov.au and/or www.ncirs.edu.au

Help me grow and learn

Children develop at different rates and need help to grow and learn.

Use this checklist to keep track of your baby's development. If you are concerned seek help.

In my first year	Age first noticed
I am learning to talk and can	
Say my first clear words by 10 to 12 months such as 'Mum, mum', 'Dad, dad'	
Copy sounds and mouth movements you make by around 6 months	
Understand many words by 1 year, often up to around 50 words	
I am learning to move and can	
Roll over first from side to back then right over by about 4 to 6 months	
Sit at around 8 to 10 months	
Pull myself around using my forearms while lying on my tummy by 8 to 10 months	
Get into a crawling position by 9 to 10 months	
Stand and hold onto furniture by 10 to 12 months	
Move around holding onto furniture from about 12 months	
I am learning to use my hands and can	
Look at my hands at around 3 months	
Reach or grasp my toy using my hands at around 4 months	
Transfer a toy from one hand to another at around 6 months	
Pick up small crumbs with my finger and thumb at around 8 to 9 months	
Lie on my back and grab my foot at around 6 months	

I am learning to see and can	
Stare at faces, and look steadily at big objects and a bright light at 1 to 2 months	
Recognise the faces of special people like mum and dad at 3 months	
Follow moving objects with both eyes at 3 to 4 months	
Reach and grasp objects at 5 to 6 months	
Search for dropped objects at 5 to 7 months	
Look for hidden objects even around corners at 9 to 10 months	
I am learning to work things out and can	
Pick up a toy and put it in my mouth at around 6 months	
Bang things together at around 6 months	
I am learning to be sociable and can	
Join in games such as peek-a-boo from around 6 months	
Know family from strangers at around 6 months	
Pick up finger food at around 6 months	
Enjoy time with my family and let you know when I am happy or sad	
Let you know that I am content by 'cooing'	
Connect with people by looking at their face	

How to help me grow and learn

Your baby learns best if you spend time and play with them. Here are some ways you can do this.

- > Show me how I can move my mouth, such as poking my tongue out
- > Sing rhymes, read and talk to me
- > Put me on the floor on my tummy and stay with me when I am awake; this can help me to roll and crawl
- > Play with me at bath time (make sure I am safe and never leave me alone in the bath)
- > Remember I learn more through play than watching the TV or a DVD
- > Encourage me to play with what I enjoy such as a rattle or toy
- > Play peek-a-boo with me
- > Sing along and dance with me
- > Help me to explore and encourage my efforts, enjoy with me
- > Wave goodbye to me when you leave

When to seek help

If you are concerned about anything on the *Help me grow and learn* checklist or notice or any of the below, see a child and family health nurse or doctor.

If your baby is

- > Not making any sounds by 3 months
- > Not saying words by 12 months
- > Not sitting by 12 months
- > Not picking things up e.g. toy, finger food by 8 months
- > Not following moving objects or bright lights with their eyes by 3 months
- > Not relating well to others by 12 months
- > Or if their eyes are not moving together by 3 months

A child and family health nurse or doctor can listen, reassure or provide referrals to services that can help your child.

More detailed information is available on www.cyh.com or call the Parent Helpline 1300 364 100

1-4 week health check

(Assessment by child and family health nurse, midwife, GP or Paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment (tick all items)			Appropriate	Follow up	Refer
Weight	gm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/palate			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (observation/appearance)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including reflexes, responsiveness/tone)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular (doctor only)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Umbilicus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Femoral pulses			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal region			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Feeding

Only breastmilk Yes No

Breastmilk + formula Yes No

Only infant formula Yes No

Weight gain [since hospital discharge]

Comments:

.....

Plan

Topics discussed: SIDS safe sleep environment settling feeding
maternal health immunisation community services (refer to 'what I need' in this section)

Attended with

Name (printed)

Signature Designation

Venue Date of check /...../..... Time

1-4 week health check

(Assessment by child and family health nurse, midwife, GP or Paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment (tick all items)			Appropriate	Follow up	Refer
Weight	gm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/palate			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (observation/appearance)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including reflexes, responsiveness/tone)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular (doctor only)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Umbilicus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Femoral pulses			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal region			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Feeding

Only breastmilk Yes No
 Breastmilk + formula Yes No
 Only infant formula Yes No

Weight gain [since hospital discharge]

Comments:

Plan

Topics discussed: SIDS safe sleep environment settling feeding
 maternal health immunisation community services (refer to 'what I need' in this section)

Attended with

Name (printed)

Signature Designation

Venue Date of check / / Time

6-8 week health check (Assessment by GP or paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment <i>(tick all items)</i>			Appropriate	Follow up	Refer
Weight	gm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/palate			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (observation/fixation and following)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including reflexes, responsiveness/tone)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular <i>(doctor only)</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Umbilicus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Femoral pulses			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal region			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Immunisation (age appropriate completed as per schedule) Yes No

Feeding

Only breastmilk Yes No
 Breastmilk + formula Yes No
 Only infant formula Yes No

Weight gain [since hospital discharge]

Comments:

Plan

Topics discussed: SIDS safe sleep environment settling feeding
 maternal health immunisation community services (refer to 'what I need' in this section)

Attended with

Name (printed)

Signature Designation

Venue Date of check / / Time

6-8 week health check (Assessment by GP or paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment <i>(tick all items)</i>			Appropriate	Follow up	Refer
Weight	gm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/palate			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes (observation/fixation and following)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including reflexes, responsiveness/tone)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular <i>(doctor only)</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Umbilicus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Femoral pulses			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal region			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Immunisation (age appropriate completed as per schedule) Yes No

Feeding

Only breastmilk Yes No
 Breastmilk + formula Yes No
 Only infant formula Yes No

Weight gain [since hospital discharge]

Comments:

Plan

Topics discussed: SIDS safe sleep environment settling feeding
 maternal health immunisation community services (refer to 'what I need' in this section)

Attended with

Name (printed)

Signature Designation

Venue Date of check / / Time

6-9 month health check

(Assessment by child and family health nurse, GP or paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment (tick all items)			Appropriate	Follow up	Refer
Weight	kg	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference	cm	%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observation			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fixation/following			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal light reflections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral health 'lift the lip' check			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips (abduction)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental check			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milestones checklist			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ages and stages questionnaire			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Immunisation (age appropriate completed as per schedule) Yes No

Feeding at 4 months

Only breastmilk Yes No Breastmilk + formula Yes No

Only infant formula Yes No

Feeding to 6 months

Only breastmilk Yes No Breastmilk + infant formula Yes No

Only infant formula Yes No Solids at 6 months Yes No

Topics discussed: SIDS safety safe sleep environment settling feeding
teeth introducing solids play immunisation community services
(refer to 'what I need' in this section)

Comments:

Plan

Attended with

Name (printed)

Signature Designation

Venue Date of check/...../..... Time

6-9 month health check

(Assessment by child and family health nurse, GP or paediatrician)

Name

Date of birth/...../.....

Sex M / F

Health assessment (tick all items)	Appropriate	Follow up	Refer
Weight kg %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length cm %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head circumference cm %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head shape (including fontanelles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fixation/following	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal light reflections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral health 'lift the lip' check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips (abduction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testes fully descended R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milestones checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ages and stages questionnaire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing

UNHS complete Yes No

Immunisation (age appropriate completed as per schedule) Yes No

Feeding at 4 months

Only breastmilk Yes No Breastmilk + formula Yes No

Only infant formula Yes No

Feeding to 6 months

Only breastmilk Yes No Breastmilk + infant formula Yes No

Only infant formula Yes No Solids at 6 months Yes No

Topics discussed: SIDS safety safe sleep environment settling feeding
teeth introducing solids play immunisation community services
(refer to 'what I need' in this section)

Comments:

Plan

Attended with

Name (printed)

Signature Designation

Venue Date of check/...../..... Time

