



Child Profile

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I. Identifying Information NOTE: Fields with (*) asterisk are required fields

1. Facility Location*		Region		Province		City/Municipality		Barangay		No. & Street Address	
2. Name of Facility*						3. Service Provider*					
4a. Name*						4b. Nickname					
Last Name*		First Name*		Middle Name*		Ext.(Jr.Sr.)					
5. Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female		6a. Birth Order*		6b. No. of siblings*		7a. Date of Birth*					
8. Birthplace*						7b. Birth Registered* <input type="checkbox"/> Yes <input type="checkbox"/> No					
9. Home Address*		Region		Province		City/Municipality		Barangay		No. & Street Address	
10. Religion				11. Ethnicity							

II. Nutrition and Services

<p>12. The child underwent the following: (check all applicable and fill details)</p> <p><input type="checkbox"/> Breastfeeding Kind of Breastfeeding <input type="checkbox"/> Exclusive <input type="checkbox"/> Mixed</p> <p>Breastfed for <input type="text"/> months</p> <p><input type="checkbox"/> Supplementary Feeding – supplemented for <input type="text"/> days</p> <p><input type="checkbox"/> Child have Disability/Impairment Has the child been referred for assistance / assessment or other services in connection with his/her disability/impairment?*</p> <input type="text"/>				<p>13. The child has the following disabilities/impairments:</p> <table border="1"> <thead> <tr> <th>a. Disability / Impairment (e.g. hearing, speech visual)</th> <th>b. Cause (e.g.inborn,illness)</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td></tr> <tr><td>2.</td><td></td></tr> <tr><td>3.</td><td></td></tr> <tr><td>4.</td><td></td></tr> <tr><td>5.</td><td></td></tr> </tbody> </table>				a. Disability / Impairment (e.g. hearing, speech visual)	b. Cause (e.g.inborn,illness)	1.		2.		3.		4.		5.	
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1.																			
2.																			
3.																			
4.																			
5.																			
<p>14. The child has the following past ECCD experiences:</p> <table border="1"> <thead> <tr> <th>a. Service Type (e.g.Center, Community)</th> <th>b. Service (e.g. Child Minding, Day Care Mother)</th> <th>c. From (Start Date) (YYYY-MM-DD)</th> <th>d. To (End date) (YYYY-MM-DD)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				a. Service Type (e.g.Center, Community)	b. Service (e.g. Child Minding, Day Care Mother)	c. From (Start Date) (YYYY-MM-DD)	d. To (End date) (YYYY-MM-DD)												
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<p>15a. Participation Fee <input type="checkbox"/> Paid amount of:</p>		<p>17. Scheduled Session* <input type="checkbox"/> Morning Session <input type="checkbox"/> Afternoon Session</p>		<p>15b. Parent's Counterpart <input type="checkbox"/> Cash <input type="checkbox"/> In Kind <input type="checkbox"/> None <input type="checkbox"/> Cash / In Kind</p>		<p>18. Attendance Status* <input type="checkbox"/> Continuing <input type="checkbox"/> Dropped Out <input type="checkbox"/> Graduated</p> <p>If drop out, reason: <input type="checkbox"/> Illness <input type="checkbox"/> Transfer of Residence <input type="checkbox"/> Others (specify): <input type="text"/></p>		<p>Accomplished By* <input type="text"/> Name and Signature of ECCD Service Provider</p>											
<p>16. School Year*</p>				<p>Date Accomplished* YYYY - MM - DD</p>				<p>Encoder ID: <input type="text"/></p>											



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III. Health Services Have the Health Service Provider sign beside each entry (use additional sheets as necessary)

19a. Health Service*	b. Date YYYY-MM-DD	19a. Health Service*	b. Date YYYY-MM-DD
1. Newborn Screening		25.	
2. BCG Vaccination (at birth)		26.	
3. DPT Vaccination (6, 20 & 14 weeks old)		27.	
4. OPV Vaccination (6, 20 & 14 weeks old)		28.	
5. Hepatitis B Vaccination (6, 20 & 14 weeks old)		29.	
6. Measles Vaccination (9 months)		30.	
7. Vitamin A (starting from 6 months)		31.	
8. Deworming		32.	
9. Dental Checkup		33.	
10. Physical Checkup		34.	
11. Micronutrient Supplement		35.	
12.		36.	
13.		37.	
14.		38.	
15.		39.	
16.		40.	
17.		41.	
18.		42.	
19.		43.	
20.		44.	
21.		45.	
22.		46.	
23.		47.	
24.		48.	

IV. Nutritional Status (use additional sheet as necessary) **V. Developmental Status (Using the ECCD Checklist)**

Nutritional Log	Date YYYY-MM-DD	Age	Height (cm)	Weight (kg)	Nutritional Status		Evaluation*		1st Evaluation		2nd Evaluation		3rd Evaluation	
							Evaluation Date (YYYY-MM-DD)	Raw Score	Scaled Score	Raw Score	Scaled Score	Raw Score	Scaled Score	
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Nutritional Status Interpretation

Weight-for-Age

1	<-2SD	Underweight	1	Highly Advanced
2	-2SD to +2SD	Normal	2	Slightly Advanced
3	>+2SD	Overweight	3	Average Development
4	Development to be mentioned after 6 months			
5	Development to be mentioned after 3 months			

Reviewed By*

Name and Signature of ECCD Service Provider

Date Accomplished*

 YYYY - MM - DD

Encoder ID

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Nutritional Status (e.g. overweight, underweight, normal, malnourished)