Bright Futures Parent Handout
5 and 6 Year Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

ORAL HEALTH

Healthy Teeth

- Help your child brush his teeth twice a day.
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss her teeth once a day.
- Your child should visit the dentist at least twice a year.

SCHOOL READINESS

Ready for School

- Take your child to see the school and meet the teacher.
- Read books with your child about starting school.
- Talk to your child about school.
- Make sure your child is in a safe place after school with an adult.
- Talk with your child every day about things he liked, any worries, and if anyone is being mean to him.
- Talk to us about your concerns.

MENTAL HEALTH

Your Child and Family

- Give your child chores to do and expect them to be done.
- Have family routines.
- Hug and praise your child.
- Teach your child what is right and what is wrong.
- Help your child to do things for herself.
- Children learn better from discipline than they do from punishment.
- Help your child deal with anger.
  - Teach your child to walk away when angry or go somewhere else to play.

NUTRITION AND PHYSICAL ACTIVITY

Staying Healthy

- Eat breakfast.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Limit candy, soft drinks, and high-fat foods.
- Offer 5 servings of vegetables and fruits at meals and for snacks every day.
- Limit TV time to 2 hours a day.
- Do not have a TV in your child's bedroom.
- Make sure your child is active for 1 hour or more daily.

SAFETY

Safety

- Your child should always ride in the back seat and use a car safety seat or booster seat.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Have a working smoke alarm on each floor of your house and a fire escape plan.
- Install a carbon monoxide detector in a hallway near every sleeping area.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Teach your child how to cross the street safely. Children are not ready to cross the street alone until age 10 or older.
- Teach your child about bus safety.
- Teach your child about how to be safe with other adults.
  - No one should ask for a secret to be kept from parents.
  - No one should ask to see private parts.
  - No adult should ask for help with his private parts.

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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5 Year Parent Questionnaire

Please complete this side only

Interval History/New Problems

Has there been any change in general family history since last visit? ❑ yes ❑ no

If "yes", please specify: ____

Any changes at home since last visit? ❑ yes ❑ no

If "yes", please specify: ____

General

Do you have any concerns or worries about your child? ❑ yes ❑ no

If "yes", please specify: ____

Is your child attending preschool? ❑ yes ❑ no

If "yes", where? ____

Is your child attending kindergarten? ❑ yes ❑ no

If "yes", where? ____

Do you have concerns about your child's vision/hearing? ❑ yes ❑ no

If "yes", please specify: ____

Nutrition

What type of milk does your child drink?

❑ Whole milk/2%/1%/nonfat ____ oz/day ❑ Other (Almond Milk/Soy Milk/Hemp Milk)

Does your child eat a good variety of foods (meat, vegetables, grains, fruit)? ❑ yes ❑ no

Do you eat meals as a family? ❑ yes ❑ no

Sleep

How many hours of sleep does your child get each night on average? ____

Does your child nap? ❑ yes ❑ no

Elimination

Does your child have normal bowel movements? ❑ yes ❑ no

Is your child toilet trained? daytime: ❑ yes ❑ no

night: ❑ yes ❑ no

Development

Do you have any concerns about your child's development or behavior? ❑ yes ❑ no If yes, explain:

____

Question		
Does your child run, jump, hop and skip?		
Does your child balance on one foot?	❑ yes	❑ no
Can your child bathe and get dressed without help?	❑ yes	❑ no
Does your child draw a person with at least 6 body parts?	❑ yes	❑ no
Can your child draw a square and a triangle?	❑ yes	❑ no
Can your child print/write some letters and numbers?	❑ yes	❑ no
Can your child count to ten?	❑ yes	❑ no
Can your child name at least 4 colors?	❑ yes	❑ no
Can your child tell a simple story?	❑ yes	❑ no
Does your child know his/her own telephone number?	❑ yes	❑ no
Does your child recognize most letters of the alphabet?	❑ yes	❑ no

Safety

Question			
Does your child know how to get out of your home in the event of a fire?		❑ yes	❑ no
Does your child wear a helmet while biking, skating, scootering and skiing?		❑ yes	❑ no
Does your child ride in a booster seat in the back seat of the car?		❑ yes	❑ no
Does your house have working smoke detectors?		❑ yes	❑ no
Are all medicines and household products in locked cabinets?		❑ yes	❑ no
Have you discussed strangers and privacy with your child?		❑ yes	❑ no
Does anyone smoke who cares for your child?		❑ yes	❑ no
If there is a gun in your home, is it kept locked and unloaded?	❑ no gun	❑ yes	❑ no

Completed by: ____ Relationship to Patient: ____ Date: ____

End of parent questionnaire

Provider review ____:

Patient Name: ____ DOB: ____