



Child Information Sheet

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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* Male Female 6a. Birth Order* 6b. No. of siblings* 7a. Date of Birth*
YYYY - MM - DD

8. Birthplace* 7b. Birth Registered*
YYYY - MM - DD

9. Home Address*
Region Province City/Municipality Barangay No. & Street Address

10. Religion 11. Ethnicity

II. Nutrition and Services

12. The child underwent the following: (check all applicable and fill details)

- Breastfeeding
 Kind of Breastfeeding
 Exclusive Mixed
 Breastfed for months
- Supplementary Feeding – supplemented for days
- Child have Disability/Impairment
 Has the child been referred for assistance / assessment or other services in connection with his/her disability/impairment?*
-
- Listahanan Identified
- Pantawid Beneficiary Household ID

13. The child has the following disabilities/impairments:

a. Disability / Impairment (e.g. hearing, speech visual)	b. Cause (e.g.inborn,illness)
1.	
2.	
3.	
4.	
5.	

14. The child has the following past ECCD experiences:

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)

15a. Participation Fee
 Paid amount of:

17. Scheduled Session*
 Morning Session
 Afternoon Session

15b. Parent's Counterpart
 Cash
 In Kind
 None

18. Attendance Status*
 Continuing
 Dropped Out
 Graduated

16. School Year*

If drop out, reason:
 Illness
 Transfer of Residence
 Others (specify):

Accomplished By*

 Name and Signature of ECCD Service Provider

Date Accomplished*
YYYY - MM - DD

Encoder ID



Child Information Sheet

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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		
1. Newborn Screening			
2. BCG Vaccination (at birth)			
3. DPT Vaccination (6, 20 & 14 weeks old)			
4. OPV Vaccination (6, 20 & 14 weeks old)			
5. Hepatitis B Vaccination (6, 20 & 14 weeks old)			
6. Measles Vaccination (9 months)			
7. Vitamin A (starting from 6 months)			
8. Deworming			
9. Dental Checkup			
10. Physical Checkup			
11. Micronutrient Supplement			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			

19a. Health Service*	b. Date YYYY-MM-DD		
25.			
26.			
27.			
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31.			
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42.			
43.			
44.			
45.			
46.			
47.			
48.			

IV. Nutritional Status (use additional sheet as necessary)

Nutritional Log	Date YYYY-MM-DD	Age	Height (cm)	Weight (kg)	Nutritional Status
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					

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

V. Developmental Status (Using the ECCD Checklist)

Evaluation*	1 st Evaluation		2 nd Evaluation		3 rd Evaluation	
Evaluation Date (YYYY-MM-DD)						
Domains	Raw Score	Scaled Score	Raw Score	Scaled Score	Raw Score	Scaled Score
a. Fine Motor Development						
b. Gross Motor						
c. Self-Help						
d. Receptive Language						
e. Expressive Language						
f. Cognitive						
g. Socio Emotional						
Overall Interpretation						

Nutritional Status		Developmental Status Interpretation				
Weight-for-Age		1	Highly Advanced			
1 <-2SD	Underweight	2	Slightly Advanced			
2 -2SD to +2SD	Normal	3	Average Development			
3 >+2SD	Overweight	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*

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YYYY - MM - DD

Encoder ID

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