Practice Parameters for Primary Health Care

Given the prenatal and environmental risk factors with which children and adolescents enter the foster care system and the illness profiles described by the studies listed in the bibliography in Chapter 1, it is imperative that primary care physicians who care for children and adolescents in foster care view them as children with special health care needs. Primary care physicians must maintain a high index of suspicion for a multitude of physical, developmental, educational, dental, and behavioral conditions. In addition, because of the unique environment in which children and adolescents in foster care live and the bureaucratic and regulatory structure that surrounds them, primary care physicians must approach the task of providing services to these children and adolescents with a very special perspective. The following describes general principles of practice that must govern the delivery of health care to children and adolescents in foster care and the characteristics of the foster care medical home.

Principles of Practice

Interaction With Child Welfare Personnel

Health care professionals must be prepared to work closely with the social service agencies responsible for children and adolescents in foster care. Information must flow freely between social service and medical staff to ensure optimal care (*see* Chapter 5).

Communication With Birth and Foster Parents

In addition to interacting with social service staff, health care professionals must communicate effectively with foster parents and, when

available, birth parents. If the ultimate goal for children is family reunification, health care professionals must make every effort to engage birth parents in the health care of the children. Child welfare and health care management staff (*see* Chapter 5) can facilitate the involvement of birth parents. Information must be shared in a culturally sensitive and easily understood manner.

Health Education and Wellness Promotion

Health education is essential to providing effective health care to this population. Efforts to provide health education should be directed toward the social service staff, consulting staff, foster parents, birth parents, and children and adolescents. Adolescents aging out of foster care should have extensive health education prior to final discharge.

Intensity of Encounters

Given the multitude of health, developmental, and emotional issues that children and adolescents in foster care have and the number of individuals with whom information must be shared, it is evident that health care professionals must be prepared to devote significantly more time to their encounters with children and adolescents in foster care.

Medical History

Social service and medical staff must make every effort to obtain complete medical histories on children and adolescents as they enter foster care. However, health care professionals must be prepared to provide services to children and adolescents with little or no medical information available, especially early in placement. Ideally, while in foster care, each child will have a centralized medical record and/or file at the foster care agency that is updated on a regular basis.

Child Abuse and Neglect Issues

It is never more important for the health care professional to act as a child advocate than when caring for children and adolescents in foster care. Health care professionals must be able to adequately assess

children for child abuse and neglect issues at entry to foster care. In addition, they must always be alert to signs of suboptimal caregiving on the part of foster parents. Growth parameters must be diligently followed, as growth failure often is the first sign of mismatch between children and foster homes. Observing interactions between foster parents and children in the office setting allows health care professionals to assess the quality of the parent-child relationship and whether there is a mismatch. And of course, health care professionals always must be alert to signs or symptoms of frank neglect or abuse. Primary care physicians must communicate any concerns about the foster care placement or visitation as soon as possible to the appropriate child welfare staff.

Special Training

In addition to maintaining competency in all areas of general pediatrics, primary care physicians who work with children in foster care must be

- Well-versed in the topics of abuse and neglect
- Well-versed in infant, child, and adolescent development
- Cognizant of the impact of foster care on families and children
- Comfortable dealing with significant behavioral and psychiatric disorders, in cooperation with mental health professionals
- Familiar with the child welfare system and its policies and procedures and able to navigate through its bureaucratic structure, working closely with health care managers

Coordination of Multiple Health Care Needs

Given the complexity of the physical, emotional, and developmental health conditions of children and adolescents in foster care, a multidisciplinary treatment plan is often indicated. Because many specialists may be involved in the care of a particular child, primary care physicians must be prepared to coordinate myriad services and ensure that information flows easily between specialists, social services, and primary care physicians.

The Medical Home Model for Children and Adolescents in Foster Care

Children and adolescents in foster care have experienced episodic, fragmented, and inadequate health care prior to foster care and, once in foster care, it is not unusual for them to experience multiple changes in foster home placement, leading to further disruption in health services. It is imperative that this population has consistency in its health care. According to the American Academy of Pediatrics (AAP) and the federal Maternal and Child Health Bureau, a medical home for any child has certain characteristics. It is a medical practice that is accessible and family-centered and provides high-quality care that is comprehensive, coordinated, compassionate, and continuous over time. In addition to these qualities, a foster care medical home should be staffed by pediatric health care professionals who understand the effect of foster care on children and families, are familiar with the regulations and mandates of child welfare, and have expertise in child abuse and neglect. In addition, physicians in foster care health care must be willing to work in collaborative cooperative partnership with child welfare personnel, foster and birth parents, and multiple other professionals on behalf of these children and families.

Children and adolescents in foster care should receive all of their health care services (ie, routine preventive, acute illness, chronic illness) from a single health care professional who will get to know them, with whom they can bond, and in whom they can confide. They need to be able to point to a health care professional and enthusiastically proclaim, "That's my doctor!"

Parameters for Primary Health Care

This section details the components of primary health care encounters that are specific to children and adolescents in foster care. For each encounter, the purpose, time frame for its accomplishment, type of health care professional involved, and procedures to be performed

are described. These details are provided for the following types of encounters or events:

- Health Information Gathering at Time of Removal
- Initial Medical Screen
- Ongoing Health Information Gathering
- Comprehensive Health Assessment
- Follow-up Assessment
- Periodic Preventive Health Care
- Discharge Encounter
- Other Encounters Unique to Foster Care
  - Intra-Agency Transfer
  - Return to Care Within 90 Days
  - Return to Care After 90 Days
  - Visitation With Birth Parents

Health Information Gathering at Time of Removal

Purpose

1. To identify medical, developmental, and mental health conditions that require prompt medical attention*
2. To identify chronic physical, developmental, and mental health conditions that will require ongoing therapy
3. To identify health conditions that will affect the selection of a foster home

**Refer to a pediatric ambulatory service or pediatric emergency department for conditions warranting immediate attention.*

Time Frame

At the time of removal.

Performed By

Child welfare staff (with medical consultation as indicated).

Components

1. Information to be obtained
   - Site of ongoing health care (eg, clinic, physician office) prior to foster care placement—this is crucial because most of the following information will be obtained from these sources
   - Chronic medical, developmental, or mental health conditions (eg, asthma, sickle cell disease, seizure disorder, diabetes, autism, depression)
   - Hospitalizations, including psychiatric and residential treatment (when/where/why)
   - Surgery (when/where/why)
   - Medication (names/indications/doses)
   - Allergies (eg, food, medication, insect stings)
   - Hospital of birth
2. Items to accompany child
   - Eyeglasses
   - Medication
   - Medical equipment (eg, nebulizer, spacer, orthotics, hearing aids)
   - Immunization record
3. Information on newborns discharged from nursery into foster care
   - Discharge summary
   - Follow-up appointments
   - State newborn screening form
   - Immunization record
   - Results of newborn hearing screening

Initial Medical Screen

Purpose

1. To identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy (eg, asthma, diabetes, seizure disorder), signs of abuse or neglect, signs of infection or communicable diseases (eg, varicella, lice,

tinea), hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances
2. To identify health conditions that should be considered in making placement decisions

Time Frame

Within 24 hours of removal.

Performed By

Child welfare staff or designated primary care physician. (Ideally, this will be the child's medical home while in foster care.)

Components

1. Review of available medical, developmental, and mental health history
2. Review of systems (standard medical review)
3. Symptom-targeted examination to include
   - Vital signs (with blood pressure measurement if 3 years or older)
   - Height and weight (and head circumference, if younger than 3 years) with percentiles, and calculate body mass index
   - If indicated or available, physical examination by physician or pediatric nurse practitioner (Ideally, this is included at this visit.)
   - External body inspection (unclothed) for signs of acute illness, signs of abuse (unusual bruises, welts, cuts, burns, trauma), and rash suggestive of infestation or contagious illness; range-of-motion examination of all joints by health staff
   - External genitalia inspection for signs of trauma, discharge, or obvious abnormality by health staff
   - Assessment of chronic conditions (eg, respiratory status if known to have asthma)
4. Developmental and mental health screen (using standard screening tool) for
   - Significant developmental delay

- Major depression
- Suicidal thoughts
- Violent behavior

5. Actions that may be required after medical screen
   Referral to primary care physician, pediatric ambulatory service, or pediatric emergency department for conditions warranting immediate attention or evidence of abuse warranting further evaluation, documentation, and treatment. For history and/or physical findings suspicious for sexual abuse, referral is recommended to a center with staff that specializes in evaluation, documentation, and treatment of sexual abuse (*see* Chapter 4).

Ongoing Health Information Gathering

Purpose

1. To identify past and ongoing health, behavioral, and developmental conditions
2. To obtain necessary information not documented at time of removal
3. To supplement information documented at the time of removal
4. To begin the process of developing a comprehensive profile of the child or adolescent and birth parents

Time Frame

Begin as soon as possible after placement. This is an ongoing process that begins at removal and continues while the child or adolescent is in care. As much of the past medical history as possible should have been gathered prior to the comprehensive health assessment for review by health care professionals.

Performed By

Health care manager.

Components

1. Complete medical history
   - Chronic medical conditions (eg, asthma, sickle cell disease, seizure disorder)

- Hospitalizations (when/where/why)
- Surgery (when/where/why)
- Medication (names/indications/doses)
- Allergies (eg, food, medication, insect stings)
- Immunization record

2. Complete perinatal history
   For all children from birth to 6 years of age and older children as appropriate.
   - Hospital of birth
   - Mother's age/gravidity/parity
   - Prenatal care
   - Illnesses or infections during pregnancy
   - Medications during pregnancy
   - Drugs, alcohol, or tobacco use during pregnancy
   - Problems with labor or delivery; type of delivery
   - Gestational age
   - Weight, length, and head circumference at birth
   - Apgar scores
   - Urine toxicology results; other laboratory tests including syphilis serology and hepatitis screen
   - Problems in nursery or neonatal course (eg, respiratory problems, jaundice, feeding difficulties, cardiac problems, neurologic problems)
   - State newborn screen results; hearing screen results
3. Family medical history
   A complete family medical history should be obtained with particular attention to asthma, tuberculosis, hepatitis, sexually transmitted diseases, human immunodeficiency virus (HIV) infection, drug and alcohol use, genetic disorders, developmental and learning issues, and psychiatric illness.
4. Developmental history of child
   For all children from birth to 6 years of age and older children as appropriate.

5. Psychosocial history†
   - Reasons for placement in foster care
   - Type of placement
   - History of previous placements and preventive services
   - Household composition (ie, history of child's living arrangements over time)
   - Family interactions
   - Status of siblings
   - History of domestic violence
   - History of child abuse and/or sexual abuse
   - History of drug or alcohol abuse by family members or caregivers
   - Occupation and education of parent(s)
   - Child care arrangements
   - Prior housing and living arrangements (eg, homelessness, frequent moves)

   †*Psychosocial report prepared by child welfare staff, if complete, could serve as the source of this information.*

6. Behavioral and mental health history of child or adolescent
   To include any mental health diagnoses, the use of psychotropic medications, inpatient and outpatient therapy, and history of substance abuse.‡

   ‡*Informed consent by the child's legal guardian is required for the administration of psychotropic medications to children in foster care (*see *chapters 6 and 7).*

7. Nutritional history
   - For infants: breastfeeding or formula feeding, solids and age of introduction, use of vitamins, fluoride, and iron
   - Food allergies, food intolerance, and food preferences
   - Dietary restrictions of any kind

8. School history
   - Current child care, preschool, or school placement
   - Early intervention programs, preschool special education, or special education programs (The results of testing that has been performed should be requested.)

- Past or current need for special services (eg, special education, occupational therapy, physical therapy, speech therapy)
- School performance and behavior

9. Request for records
   Medical records from the following should be requested as soon as possible after a child or adolescent enters foster care:
   - Past and current primary care physicians
   - Specialty care professionals
   - Medical centers where child was hospitalized, including center of birth
   - Local immunization registry
   - Previous foster care agencies
   - Early intervention programs, preschool special education programs, and special education programs (The results of testing and individualized educational plans should be requested.)
   - Mental health professionals
   - Schools (They are important resources for immunization records.)
   - Dental professionals
10. Consent from birth parents
    The initial contact with birth parents should be used as an opportunity to obtain consent for routine and emergency medical care, as well as for the release of past medical records, as per state regulations. Each state has regulations addressing the timeliness of consents and who may sign consents (*see* Chapter 6).
11. Foster parents update
    All significant medical information should be shared with the foster parents as soon as possible after it becomes available to the caseworker, health care professional, and/or child welfare staff.

An appointment should be scheduled for birth parents or other prior caregivers to meet with health care professionals and their staff as soon as possible after placement in foster care. A complete history then can be obtained by health professionals directly. This encounter also serves to involve birth parents in the treatment plan.

Comprehensive Health Assessment

Purpose

1. To review all available data and medical history about the child or adolescent
2. To identify medical conditions
3. To identify developmental and mental health conditions requiring immediate attention
4. To develop an individualized treatment plan

Time Frame

Within 30 days of foster care placement (preferably as soon as possible following placement).

Performed By

Pediatric nurse practitioner or physician of child care agency or primary care physician. The health care professional who performs the comprehensive health assessment ideally should continue to follow the child or adolescent throughout his or her stay in foster care, and possibly beyond (*see* "Standards for Health Care for Children and Adolescents in Foster Care," Chapter 1, page 4).

Attended By

Children or adolescents, foster parents, health care manager, caseworkers, and, when possible, birth parents.

Components

1. Elicit or review complete medical, behavioral, developmental, and social history when possible.
2. Review of systems (ie, standard medical review).
3. Complete unclothed physical examination, including genital examination.
4. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment with appropriate reporting. The use of figure drawings is helpful; photographs may be taken. Any history or physical findings suggestive of sexual abuse must be fully evaluated, documented, and reported.

Primary care physicians with limited experience in this area should refer to a specialty center (*see* Chapter 4).

5. Family planning and sexual safety counseling services and appropriate examination should be provided for sexually active females as soon as possible. This should be performed by the primary care physician or a specialist in adolescent medicine.
6. Developmental screen with full evaluation to follow.§
7. Mental health screen with full evaluation to follow.§

   §See *Chapter 3.*

8. Adolescent survey (ie, discussion with adolescent) to include at a minimum
   - Family relationships (foster and birth)
   - Adjustment to foster care
   - Peer relationships
   - Alcohol, drug, or tobacco use
   - Sexual orientation
   - Sexual activity
   - Prevention of sexually transmitted diseases (STDs) and birth control
   - Nutrition
   - Physical activity (ie, exercise)
   - School performance
   - Hobbies
   - Educational or career plans

   The use of a written questionnaire should be considered to help gather this information (*see* "Bibliography"). Counseling about these issues should be initiated with follow-up appointments, with further counseling scheduled as needed.
9. Immunization review

   Every effort should be made to locate the immunization record by the comprehensive health assessment. If this is not possible, the record should be located within 30 days so that an immunization update can be done at the follow-up visit. In the absence of an

immunization record at 60 days post-entry, immunizations should be commenced using the catch-up schedule from the AAP and Centers for Disease Control and Prevention (CDC).

10. Dental and oral evaluation
    Examination of the oral cavity by the primary care physician is an important part of the comprehensive health assessment, as well as of each periodic preventive health care visit. Anticipatory guidance for oral health appropriate for the child's age also should be a part of these health care encounters. The presence of any risk factors or abnormal findings requires referral to a pediatric oral health care professional or general practice dentist, regardless of the child's age.
    - The AAP recommends that children be referred for their first dental evaluation by 2 years of age, with earlier referrals as indicated.
    - The American Academy of Pediatric Dentistry (AAPD) recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin at 1 year of age.
11. Hearing and vision screening with referral
    - Subjective from birth to 3 years of age.
    - Objective for 3 years and older.
12. Human immunodeficiency virus risk assessment
    Health care professionals should assess patients' capacity to consent for HIV testing based on their ages, developmental ages, and abilities to comprehend what testing means and comply with follow-up. Health care professionals should assess each patient for risk of HIV infection based on history and newborn screening where available.‖

‖*Assessment of capacity to consent for HIV testing and of risk for HIV infection must be in accordance with guidelines set forth by each state for children and adolescents in foster care. Newborn HIV screening results are available in some states for all children and adolescents born in that state.*

13. Laboratory studies (if not well documented in medical records or records not available)
    - Hemoglobin or complete blood count (CBC) (all children younger than 6 years and adolescent females)
    - Lead level for children 6 months to 6 years of age, or older child if indicated
    - Hemoglobin electrophoresis for children at risk for hemoglobinopathies
    - Purified protein derivative tuberculin (PPD) (3 months and older)—must be read by health care personnel within 48 to 72 hours
    - Hepatitis B surface antigen (HBsAg) strongly recommended for all ages
    - Rapid plasma reagin (RPR) test strongly recommended for all ages
    - Urinalysis—dipstick (children older than 2 years or if indicated)
    - Human immunodeficiency virus testing if positive risk assessment and if appropriate consent has been obtained¶
    - Hepatitis C antibody screen for those at risk strongly recommended

    ¶*Procedure for obtaining consent for HIV testing and referral for testing as per state regulations.*

14. Universal precautions
    Discuss with foster parents the use of universal precautions.
15. Anticipatory guidance#
    Education and counseling is a critical component of each preventive health care encounter, especially for children and adolescents in foster care. The primary care physician should conduct a private interview with the older child and adolescent at this visit. General areas to be covered include
    - Temperament
    - Developmentally appropriate play or activities, including reading

- Physical activity and exercise
- Good parenting practices
- Discipline
- Nutrition
- Dental and oral health
- Injury prevention
- Child care arrangements

Topics for discussion with the older child and adolescent include

- Normal development
- Good health habits
- Dental and oral health
- Physical activity and exercise
- Discipline
- Sexually transmitted disease and pregnancy prevention
- Human immunodeficiency virus prevention
- Sexuality issues, including gender identity and sexual orientation
- Substance abuse issues (eg, drugs, alcohol, tobacco)
- Academic activities, including the importance of reading
- Future plans

Topics specific to foster care that should be discussed with the foster parent and older child and adolescent include

- General adjustment to new home
- Dealing with different expectations in different families
- Grief and loss issues
- Contact with birth parents, including adjustment issues around visits
- Behavioral problems that have surfaced (eg, adjustment reactions, oppositional behavior, depression, anger, attentional or impulse control problems)
- Sleep problems
- Appetite or unusual eating habits
- Enuresis or encopresis

- School placement, changes in school settings, peer relationships
- Behavioral or academic school problems
- Interaction with other children in home

#Some of this discussion may have to be delayed until the follow-up visit, depending on how long the child or adolescent has been in the home and how well the foster parent knows the child or adolescent.

16. Referrals
    For specialty or ancillary services as needed.

A summary of findings and recommendations, including an individual treatment plan, should be prepared for each child and adolescent; shared with the child or adolescent, foster parents, birth parents, social worker, and health care manager; and become part of the health record and child welfare case plan.

Follow-up Assessment

Purpose

1. To identify medical, mental health, developmental, and educational problems that have surfaced since the child or adolescent has entered foster care
2. To assess "goodness of fit" between the child or adolescent and foster parents
3. To update immunizations
4. To provide health education for issues relevant to the child's condition or issues of concern to foster parents
5. To review findings from developmental and mental health assessments (if completed)
6. To update, refine, and reinforce treatment plan (This visit provides an opportunity for the primary care physician to meet with the social worker and birth parents, when appropriate, to review findings and promote their integration into the child welfare permanency plan.)

Time Frame

30 days after the comprehensive health assessment.

Performed By

Ideally, the health care professionals in the foster care medical home, who will follow children or adolescents throughout their stay in foster care. Alternatively, pediatric nurse practitioners or physicians of child care agencies may conduct this visit.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible and appropriate, birth parents.

Components

1. Physical examinations
   - May not be necessary at this encounter unless preventive periodic health care is due at this time or an acute problem is present.
   - A weight check is imperative at this visit for children younger than 3 years. Inadequate weight gain often is the first sign of foster parent–child mismatch. Consider a weight check for all other children.
   - Conduct a brief skin inspection for signs of abuse or maltreatment, especially for children younger than 10 years or any developmentally delayed child.
2. Observation of parent-child interaction
   Close observation of the goodness of fit between foster parents and children is an important part of this encounter.
3. Discussion with foster parents about
   - Medical issues that have arisen since entry to home
   - Contact with birth parents, including adjustment issues around visits
   - Grief and loss issues
   - Behavioral problems that have surfaced

- General adjustment (eg, to home, school, or child care) and issues that have surfaced (eg, adjustment reactions, oppositional behavior, depression, anger, attentional or impulse control problems)
- Sleep problems
- Appetite issues, unusual eating habits, or food-hoarding behaviors
- Enuresis or encopresis
- School placement
- Behavioral or academic school problems
- Relationships with adults and other children in the foster home

4. Discussion with the child or adolescent
   The physician should conduct a private interview with the older child or adolescent at this visit.
   - The child's overall contentment in the new home and feelings toward the foster parents.
   - Adjustment to visitation and feelings around birth parents.
5. Immunization update
   Begin an accelerated schedule at this visit as per AAP and CDC guidelines if the record has not been located by this time, and report all vaccines to local immunization registry (if applicable).
6. Health education
   Include issues relevant to any problems identified or issues of concern to the child or adolescent, foster parents, birth parents, and/or social workers.
7. Review of specialty referrals
   Ascertain if scheduled appointments were kept, verify that reports were received, and make certain that foster parents are aware of upcoming appointments.
8. Review of treatment plan
   Review the treatment plan with the older child or adolescent, foster parents, birth parents, and/or social workers.

9. Next appointment**
   Establish the time for the next appointment with the primary care physician in the medical home, as needed (*see* the following section, "Periodic Preventive Health Care").

   ***If comprehensive developmental and mental health evaluations have not occurred or the information is not yet available, another follow-up appointment should be scheduled to review the findings and treatment plan.*

A summary of findings and recommendations, including an individual treatment plan, should be prepared for each child and adolescent; shared with the child or adolescent, foster parents, birth parents, social worker, and health care manager; and become part of the health record and child welfare case plan.

Periodic Preventive Health Care

Purpose

1. To promote overall wellness by fostering healthy growth and development
2. To identify significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings
3. To regularly assess for success of foster care placement
4. To regularly monitor for signs or symptoms of abuse or neglect
5. To provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and foster and birth parents

Time Frame

In general, more frequent preventive pediatric visits are recommended for the child or adolescent in foster care because of the multiple environmental and social issues that can adversely impact their health and development. Follow the most recent AAP "Recommendations for Preventive Pediatric Health Care" schedule with the following modifications:

- Monthly visits up to 6 months of age.
- Semiannual visits beyond 2 years of age through adolescence.
- Given the high incidence of complex medical, developmental, and mental health conditions in this population, primary care physicians will need to schedule additional visits on a case-by-case basis.

Performed By

Periodic pediatric preventive health care visits should be conducted by the foster care medical home professional to ensure the continuity of care deemed essential for this population. Alternatively, pediatric nurse practitioners or physicians of child care agencies may conduct these visits.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible and appropriate, birth parents.

Components

Follow the most recent AAP "Recommendations for Preventive Pediatric Health Care" schedule, with the following modifications:

1. History and physical examination with special attention to
   - Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment, with appropriate reporting.
   - Close monitoring of growth parameters is critical for this population. Poor weight gain often is the first sign of a suboptimal placement.
   - Assessment of capacity to consent for HIV testing and assessment of any risk for HIV infection at every periodic preventive health care visit, as per individual state regulations.
   - Observation of parent-child interaction for goodness of fit.
2. Sensory screening
   - Vision and hearing screening appropriate for the child's age.
   - Refer for specialized audiology evaluation if speech and language delay is suspected or detected.

3. Procedures
   - Immunizations
     The *Recommended Childhood and Adolescent Immunization Schedule,* which is updated yearly by the Advisory Committee on Immunization Practices of the CDC, the AAP, and the American Academy of Family Physicians (AAFP), should be followed (*see* pages 44–45). An accelerated schedule should be followed in cases of incomplete or missing immunization records. Given the multiple risk factors that children and adolescents in foster care often face, the following are recommended:
     – Hepatitis B vaccine for all infants, children, and adolescents.
     – For newborns, follow the hepatitis B immunization schedule for mothers who test positive for HBsAg if perinatal history is unknown.
     – Pneumococcal conjugate vaccine is recommended for all children up to 6 years of age.
     – Meningococcal vaccine is recommended for college-bound adolescents.
     – Influenza vaccine for all children 6 months to 2 years of age unless contraindicated or HIV status unknown
   - Annual screenings
     – Annual screening with a blood lead test for children 6 months to 6 years of age (for children with documented risk for high-dose lead exposure, screening with a blood lead test should be done according to the schedule set forth in the *Physician's Handbook on Childhood Lead Poisoning Prevention* [*see* "Bibliography"]).
     – Consider annual hemoglobin or CBC up to and including 6 years of age.
     – Consider annual hemoglobin or CBC for post-menarchal females.
4. Procedures for patients at risk
   - Purified protein derivative tuberculin annually for children in congregate care

- Purified protein derivative tuberculin every 2 to 3 years for all other children and adolescents per AAP guidelines for populations at high risk

5. Anticipatory guidance

   Education and counseling is a critical component of each preventive health care encounter with children and adolescents in foster care. The practitioner should conduct a private interview with the older child or adolescent at each preventive health visit. General areas to be discussed with foster parents include

   - Temperament
   - Developmentally appropriate play or activities, including reading
   - Visitation with birth parents
   - Ongoing support for the child and adolescent through process of foster care
   - Physical activity and exercise
   - Good parenting practices
   - Discipline
   - Nutrition
   - Dental and oral health
   - Injury prevention
   - Child care arrangements

   Topics for discussion with the older child or adolescent include

   - Normal development
   - Relationships with foster and birth parents
   - Continued adjustment to foster care
   - Good health habits
   - Dental and oral health
   - Physical activity and exercise
   - Discipline
   - Sexually transmitted disease and pregnancy prevention
   - Human immunodeficiency virus prevention
   - Drug, tobacco, and alcohol use

- Sexuality issues, including gender identity and sexual orientation
- Academic activities, including the importance of reading
- Future plans

6. Initial dental referral
   - The AAP recommends that all children be referred for their first dental evaluation by 2 years of age. Earlier dental evaluations may be appropriate for some children. Subsequent examinations should be scheduled as prescribed by the dentist.
   - The AAPD recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin by the first birthday. Oral screening by primary care physicians should occur prior to this age, with referral to dentists as deemed medically necessary.

Discharge Encounter

Purpose

1. To review medical, mental health, social, and developmental conditions identified during the child's stay in foster care
2. To identify any ongoing conditions that will require intervention after discharge
3. To ensure appropriate follow-up care after discharge
4. To convey a summary of the child's health history to appropriate caregivers and new primary care physicians

Time Frame

On final discharge from current foster care placement (this includes discharge because of reunification, adoption, independent living, or transfer to a different agency).

Performed By

Primary care physicians from the medical home or physicians of child care agency.

Attended By

Children or adolescents, foster or adopting parents/caregivers, caseworkers, and, when appropriate, birth parents.

Components

1. Review the medical record.
2. Obtain interval health history from current foster parents.
3. Complete unclothed physical examination.††

††State regulations may not require a comprehensive physical examination at the time of discharge, as long as the AAP "Recommendations for Preventive Pediatric Health Care" schedule has been followed. In the case of discharge to adoption, a comprehensive physical examination usually is required if one has not been performed within the preceding 6 months.

4. Final immunization update with reporting to local immunization registry (if applicable).
5. Conference with receiving caregiver (eg, adoptive parents, birth parents or relatives, new foster parents, agency representatives) or adolescent (ie, independent living). A detailed, written, comprehensive health history should be provided, including conditions identified while in foster care, all medications and vaccines, and the need for any ongoing interventions.

*Exception: HIV-related information must not be disclosed to the birth parents/guardians without written permission for children or adolescents with capacity to consent (*see *Chapter 6).*

6. Identify the new primary care physician, if necessary, and schedule the appointment with the new primary care physician.
7. A copy of the discharge health summary and immunization record should be given to the receiving parents or guardians or the adolescent who will be living independently. A copy should be forwarded to the receiving agency in the case of transfer between agencies. A copy also should be sent to the new primary care physician.

8. Follow-up appointments for primary, specialty, or ancillary care, including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Early Intervention Services, and/or Supplemental Security Income (SSI), should be arranged.
9. Facilitate and coordinate after-care services through the health care manager.
10. After-care health care management should continue for 3 to 6 months to ensure that follow-up appointments are kept. A public or community health nurse referral may be advantageous to ensure that recommended care and health education occur.

Other Encounters Unique to Foster Care

Intra-Agency Transfer

Purpose

1. To inform new foster parents about children's medical histories and any chronic or acute medical, developmental, or mental health conditions requiring treatment.
2. To transfer medical information to new primary care physicians in those cases in which transfer to a new home or facility involves a change in health care professional. Ideally, with an intra-agency transfer, the medical home is unchanged.
3. To screen for any signs of abuse or neglect on transfer to a new home or facility.

Time Frame

At the time of transfer to a new foster home or facility within the same agency.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, previous foster parents, new foster parents, facility staff, and caseworkers.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Referral to the primary care physician for any illnesses or injuries requiring treatment.
3. Conference with new foster parents to inform them of complete medical history of the child or adolescent and any chronic or acute medical, developmental, mental health, or dental conditions requiring treatment.
4. Copy of medical summary and immunization record forwarded to new primary care physician if the transfer involves a change in physician.
5. Transfer of medications, eyeglasses, and medical equipment to new foster parents with instructions on dispensing, storing, side effects of medication, and use of equipment; consider public or community health nurse referral for education.
6. Transfer of immunization record and health summary to new foster parents, as well as any documents needed to access health care.
7. Conference with new foster parents to include information on any upcoming and/or ongoing appointments with subspecialists or ancillary health care professionals.
8. Schedule next appointment with primary care physician.

Return to Care Within 90 Days

Purpose

1. To document any medical or mental health conditions that occurred while the child or adolescent was out of care

2. To screen for any signs of abuse or neglect inflicted while the child or adolescent was out of care

Time Frame

Within 24 hours of returning to foster care following a trial or final discharge from foster care or child's absence without leave from foster care.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, foster parents, and, when possible and appropriate, birth parents.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Referral to the primary care physician for any illnesses, injuries, or chronic health conditions requiring treatment.
3. Conference with foster parents, caregivers, and adolescents (ie, independent living) about interval medical and mental health problems.
4. Children or teens returning from an absence without leave are at heightened risk for STDs, abuse, and neglect during their unsupervised absence. Referral of adolescents for STD and pregnancy evaluation, birth control counseling, and rape crisis evaluation and counseling should be considered as indicated.
5. Conference with receiving foster parents about interval history, with transfer of any medications, equipment, and documents.
6. Establish next appointment with primary care physician.

Return to Care After 90 Days

Children and adolescents who have been out of foster care for more than 90 days should be treated as new admissions. Health care protocols should be followed as for a new foster care admission, including the initial medical screen, comprehensive health assessment, and follow-up assessment. Medical records should be available from the prior stay in foster care. A detailed interval health history should be obtained. Children and adolescents ideally should resume care with their prior medical home while in foster care.

Visitation With Birth Parents

This encounter occurs whenever a medical intervention needs to be provided around a visit with family or relatives or screening for abuse or neglect is deemed warranted around visitations.

Purpose

1. To inform or educate the birth parents of any chronic or acute medical conditions that will require treatment during visits.
2. To screen for any signs of physical abuse on leaving and/or returning to the foster home.

Time Frame

On leaving foster home for visits and/or return from birth parents' or relatives' homes, when indicated.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, foster parents, and birth parents or family members that children or adolescents are/were visiting.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Conference with birth parents to inform or educate them about any chronic or acute medical conditions that will require treatment during visits.
3. Referral to health care professionals for any illnesses or injuries requiring treatment.
4. Consider public or community health nurse referral for purposes of education or assessment of birth parents.

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Internet Resources

American Academy of Pediatric Dentistry: www.aapd.org

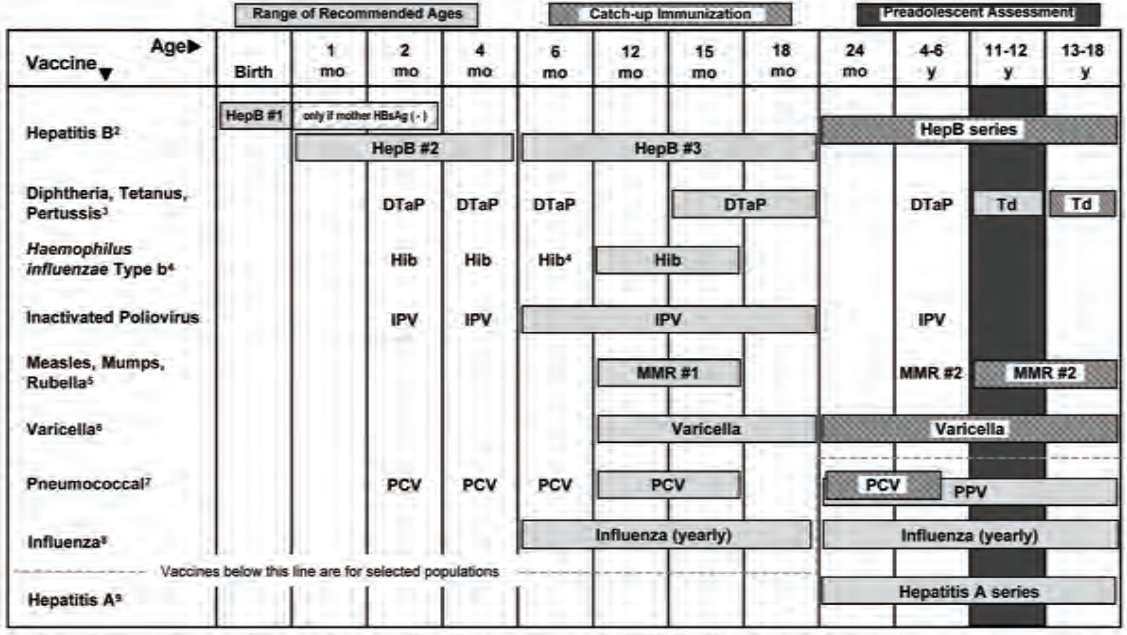
American Academy of Pediatrics: www.aap.org

Centers for Disease Control and Prevention: www.cdc.gov

The Evan B. Donaldson Adoption Institute: www.adoptioninstitute.org

National Clearinghouse on Child Abuse and Neglect Information, US Department of Health and Human Services Administration for Children & Families: nccanch.acf.hhs.gov

Recommended childhood and adolescent immunization schedule[1] — United States, July-December 2004



1. Indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of April 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. ▒▒ Indicates age groups that warrant special effort to administer those vaccines not given previously. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.org/ or by telephone, 1-800-822-7967.

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(For **necessary footnotes** and important information, see reverse side.)

2. **Hepatitis B vaccine (HepB).** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent HepB vaccine can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series; 4 doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks. Infants born to HBsAg-positive mothers should receive HepB vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 24 weeks. These infants should be tested for HBsAg and anti-HBs at 9-15 months of age. Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB vaccine series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 24 weeks.

3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered at age 12 months provided that 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid–containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use, ie PRP-OMP (PedvaxHIB® or ComVax® (Merck)) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2, 4, or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be given at age ≥12 months.

5. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not received the second dose previously should complete the schedule by the visit at age 11–12 years.

6. **Varicella vaccine (VAR).** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (ie, those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses given at least 4 weeks apart.

7. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months. It is also recommended for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1-35.

8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes) health care workers, and other persons (including household members) in close contact with persons in groups at high-risk (see *MMWR* 2004;53(No. RR-6):1–40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk of influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2003;52(No. RR-13):1–8. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6-35 months or 0.5 mL if ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups. Consult your local public health authority and *MMWR* 1999; 48(No.RR-12):1-37. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart.

Additional information about vaccines, including precautions and contraindications for vaccination and vaccine shortages is available at http://www.cdc.gov/nip or from the National Immunization Information Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish). Approved by the **Advisory Committee on Immunization Practices** (http://www.cdc.gov/nip/acip), the **American Academy of Pediatrics** (http://www.aap.org), and the **American Academy of Family Physicians** (http://www.aafp.org).

Immunization Protects Children

Regular checkups at your pediatrician's office or local health clinic are an important way to keep children healthy.

By making sure that your child gets immunized on time, you can provide the best available defense against many dangerous childhood diseases. Immunizations protect children against: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), *Haemophilus influenzae* type b, pneumococcal infections, and chickenpox. All of these immunizations need to be given before children are 2 years old in order for them to be protected during their most vulnerable period. Are your child's immunizations up-to-date?

The chart on the other side of this fact sheet includes immunization recommendations from the American Academy of Pediatrics. Remember to keep track of your child's immunizations—it's the only way you can be sure your child is up-to-date. Also, check with your pediatrician or health clinic at each visit to find out if your child needs any booster shots or if any new vaccines have been recommended since this schedule was prepared.

If you don't have a pediatrician, call your local health department. Public health clinics usually have supplies of vaccine and may give shots free.

American Academy of Pediatrics

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The information contained in this publication should not be used as a substitute for the medical advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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