






Mother Card

DANGER SIGNS

Mother ID: _____



PREGNANCY PROTECTION CARD



Pregnancy ID: _____

Name: _____ Age: _____

House No: _____

Street: _____ Area: _____

Phone No: _____

Last class completed: _____

Husband Name: _____

PREGNANCY RISKS

<input type="checkbox"/> Below 16	<input type="checkbox"/> Above 40
<input type="checkbox"/> First Pregnancy	<input type="checkbox"/> 4th or Higher Pregnancy
<input type="checkbox"/> Low BMI	<input type="checkbox"/> Low Economic Status
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Multiples
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Current TB	<input type="checkbox"/> Current Malaria
<input type="checkbox"/> Thalassemia	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Past Hepatitis Infection	<input type="checkbox"/> Infertility
<input type="checkbox"/> UTI History	<input type="checkbox"/> STD History
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Current Alcohol Abuse
<input type="checkbox"/> Alcohol Abuse History	<input type="checkbox"/> Current Drug Abuse
<input type="checkbox"/> Drug Abuse History	<input type="checkbox"/> Smoking

CURRENT PREGNANCY

Date of Registration:

LMP:

EDD from LMP:

EDD from USG:

Gravida: _____

PREGNANCY HISTORY

Living Boys	Living girls	Dead Boys	Dead Girls
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Miscarriages	MTP	Still Born	
<input type="text"/>	<input type="text"/>	<input type="text"/>	







PREVIOUS PREGNANCY











<input type="checkbox"/> Obstructed Labour	<input type="checkbox"/> Pre-Term Delivery
<input type="checkbox"/> Prolonged Labour	<input type="checkbox"/> C-Section
<input type="checkbox"/> Ante Partum Haemorrhage	<input type="checkbox"/> Post Partum Haemorrhage
<input type="checkbox"/> Eclampsia/Pre-Eclampsia	<input type="checkbox"/> Non-life Outcomes



Most Recent Pregnancies	Previous Pregnancy 1	Previous Pregnancy 2
Outcome		
Date of Birth		
Place of Birth		
Birth Attended by		
Age of Child		

Information Regarding Municipal Assistance

Mother Card

ANTENATAL CARE INFORMATION									
Initial BMI	1	2	3	4	5	6	7	8	9
									
	Antenatal Checkups								
									
	Blood Pressure								
									
	Weight								
									
	Height								
									
	Tetanus Toxoid								
	Prenatal vitamins								
									
	Folic Acid Iron Calcium Possible Days								
									
	Baby's Movement								

COUNSELLING TOPICS	
PREGNANCY CARE	
	<input type="checkbox"/>
Daytime Rest	
	<input type="checkbox"/>
No Manual Labour	
	<input type="checkbox"/>
Proper Hygiene and Sanitation	
	<input type="checkbox"/>
Family Belongingness	
NUTRITION	
Nutrition Flag	
	
MEDICATION	
	<input type="checkbox"/>
Prenatal vitamins as prescribed	
	<input type="checkbox"/>
At least 2 TT Shots	
BREAST FEEDING	
	<input type="checkbox"/>
Feeding of First Milk	
	<input type="checkbox"/>
Immediate Breastfeeding After Delivery	
	<input type="checkbox"/>
Exclusive Breastfeeding	
	<input type="checkbox"/>
No Formula or Other Liquids	
FAMILY PLANNING	
	<input type="checkbox"/>
Appropriate Contraception	

SPECIAL INITIATIVES FOR DELIVERY	
	<input type="checkbox"/>
Saving Money	
	<input type="checkbox"/>
Arrange Transportation	
	<input type="checkbox"/>
Register at Facility	

Girl Card

ILLNESS



Loose Motion



ORS - Oral Rehydration Solution



ARI - Acute Respiratory Infection



See a Doctor



High Fever



See a Doctor



Community Health Workers Are Always Available

PRACTICES FOR A HEALTHY BABY



Exclusive Breastfeeding



No Formula or Other Liquids



Mother Needs to Eat



Complementary Foods at 6 Months



A Variety of Foods



More Food as Child Gets Older



Proper Hygiene and Sanitation



Attend QIP



Appropriate Cotrimoxazole

Child ID: _____



**CALCUTTA
KIDS**

CHILD PROTECTION CARD



Name: _____

DOB: ____ / ____ / ____

Birth Weight: _____ Weeks of Pregnancy: _____

Mother ID: _____

Mother Name: _____

House NO: _____

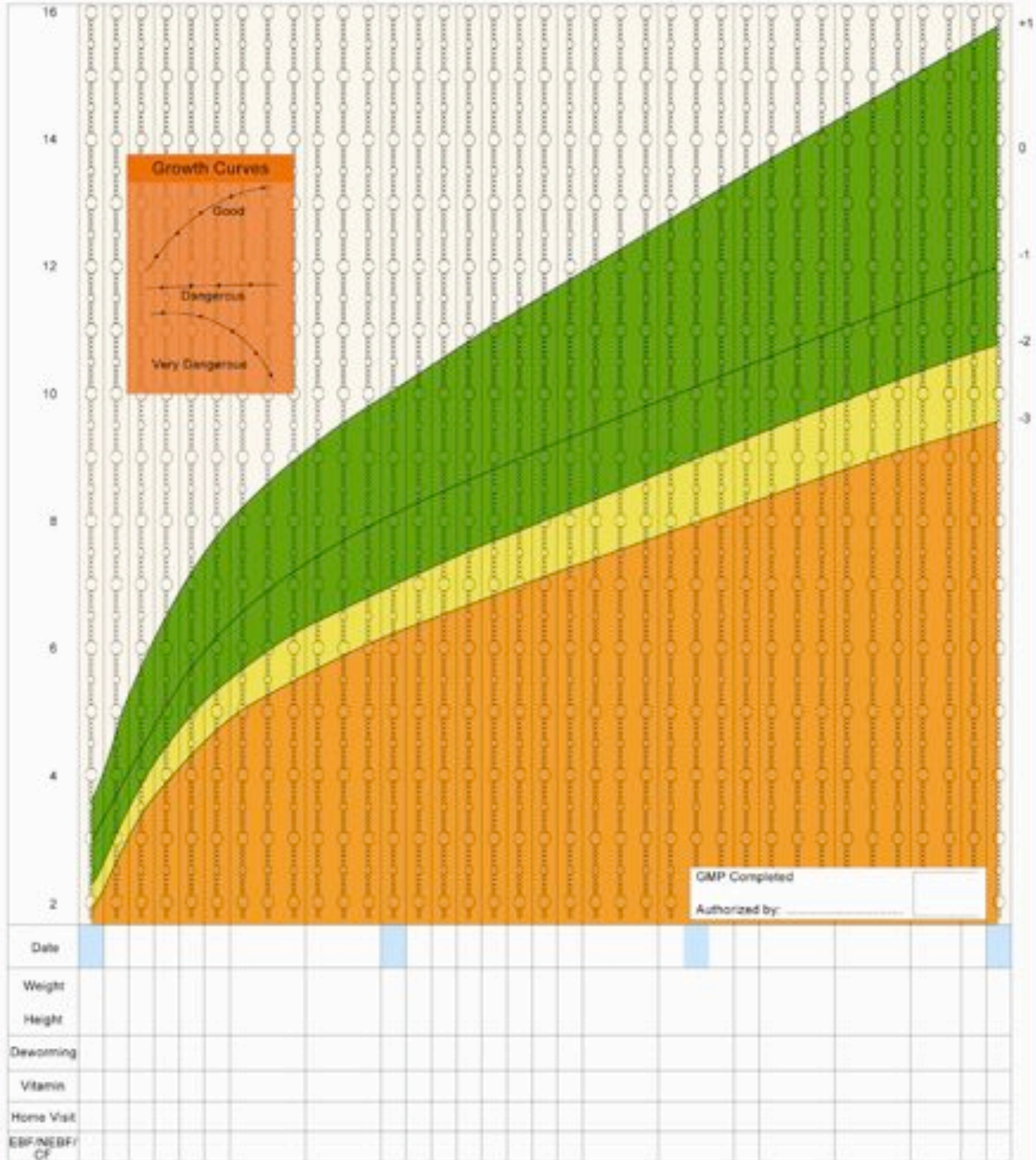
Street: _____ Area: _____

Phone No: _____

IMMUNIZATIONS

	Vaccines	Best Date	Actual Date	OK	Not OK
Birth	BCG OPV - 0	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
1-12 months	DPT - 1 OPV - 1 Hep B - 1	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
2-10 months	DPT - 2 OPV - 2 Hep B - 2	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
3-10 months	DPT - 3 OPV - 3 Hep B - 3	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
9 months	Meningo - 1 VIA - 1	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
18-24 months	DPT - 5 OPV - 5 Meningo - 2	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
18 months	VIA - 2	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
30 months	VIA - 3	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
30 months	VIA - 4	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
30 months	VIA - 5	____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>

Girl Card



Boy Card

ILLNESS



Loose Motion



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ARI - Acute Respiratory Infection



See a Doctor



High Fever



See a Doctor



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PRACTICES FOR A HEALTHY BABY



Exclusive Breastfeeding



No Formula or Other Liquids



Mother Needs to Eat



Complementary Foods at 6 Months



A Variety of Foods



More Food as Child Gets Older



Proper Hygiene and Sanitation



Attend CHC



Appropriate Contraception

Child ID: _____



**CALCUTTA
KIDS**

CHILD PROTECTION CARD



Name: _____

DOB: ____ / ____ / ____

Birth Weight: _____ Weeks of Pregnancy: _____

Mother ID: _____

Mother Name: _____

House NO: _____

Street: _____ Area: _____

Phone No: _____

IMMUNIZATIONS

	Vaccines	Best Date	Actual Date	CK Stamp	Not at CK
Birth	BCG, OPV - 0	_____	_____		<input type="checkbox"/>
1 1/2 months	OPV - 1 Hep B - 1	_____	_____		<input type="checkbox"/>
2 1/2 months	OPV - 2 Hep B - 2	_____	_____		<input type="checkbox"/>
3 1/2 months	OPV - 3 Hep B - 3	_____	_____		<input type="checkbox"/>
9 months	Mumps - 1 VA - 1	_____	_____		<input type="checkbox"/>
15-18 months	OPV - 4 OPV - 5 Mumps - 2	_____	_____		<input type="checkbox"/>
18 months	VA - 2	_____	_____		<input type="checkbox"/>
24 months	VA - 3	_____	_____		<input type="checkbox"/>
36 months	VA - 4	_____	_____		<input type="checkbox"/>
50 months	VA - 5	_____	_____		<input type="checkbox"/>
		Date			
		Date			
		Date			
		Date			

Boy Card

