POSITION STATEMENT

Preventive health care visits for children and adolescents aged 6 to 17 years: The Greig Health Record – Technical Report

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Abstract

The Greig Health Record is an evidence-based health promotion guide for clinicians caring for children and adolescents aged 6 to 17 years. It is meant to provide a template for periodic health visits that is easy to use and is easily adaptable for electronic medical records. On the Greig Health Record, where possible, evidence-based information is displayed, and levels of evidence are indicated in **boldface** for good evidence and *italics* for fair evidence.

Checklist templates include sections for weight, height and body mass index; psychosocial history and development; nutrition; education and advice; specific concerns; examination; and assessment, immunization and medications. Included with the checklist tables are three pages of selected guidelines and resources. Regular updates to the statement and tool are planned. The Greig Health Record is available in English only at http://www.cps.ca/english/CP/PreventiveCare.htm

Key Words: *Adolescents, Child health services, Children, Counselling, Evidence-based practice, Forms and records, Preventive health care, Primary prevention, Screening*

Introduction

Health care providers appreciate tools that help streamline office visits and serve as an *aide-mémoire* for the application of evidence-based guidelines. The Rourke Baby Record is an excellent example of such a tool [1]. Searches for a similar tool for periodic health visits for older children and adolescents were unsuccessful in finding an appropriate model. To fill this gap, the Greig Health Record templates were created using the model of the Rourke Baby Record [1]. It is hoped that these templates will provide a framework for standardized visits, provoke discussion and perhaps stimulate research.

Statement development

This statement was developed by first searching for available tools and recommendations for periodic health visits for children and adolescents aged 6 to 17 years. PubMed searches were performed using the terms "anticipatory guidance", "preventive services," "prevention," "screening" and "health promotion" in the years 1987 to 2009. It was hoped that a tool would be found that was evidence-based, simple to use, held data in column form for easy comparison year-to-year and was easily adaptable for electronic medical records. No such tools were found, but major guidelines have been produced by the Canadian Task Force on the Periodic Health Examination [2], the United States Preventive Services Task Force [3], the American Academy of Pediatrics [4], the American Academy of Family Practice and the Maternal Child Health Bureau (through Bright Futures) [5], and the American Medical Association (through the Guidelines for Adolescent Preventive Services) [6].

Common elements were noted and the literature was reviewed for each element to determine its level of evidence. This included a formal review by a clinical paediatric epidemiologist, Dr. E. Constantin.

Checklist tables for the Greig Health Record are a synthesis of compiled information to form an evidence-based tool that can be used for the periodic health visits.

Levels of evidence and limitations

Evidence-based information for children and adolescents aged 6 to 17 years is lacking, and there is little agreement

among guidelines [7][8]. Decisions to include elements were based primarily on consensus opinions and review of existing guidelines. Where possible, evidence-based information has been used and levels of evidence were indicated.

The support for each element in the Greig Health Record template is noted in **boldfaced type** for good evidence (grade A), *italics* for fair evidence (grade B) and normal typeface for consensus recommendations (grade C) [9]. Note that the grade of evidence indicated reflects the usefulness of each manoeuvre, not whether office-based counselling was found to be effective for each manoeuvre. For example, the use of bicycle helmets is clearly effective in reducing head injuries; however, evidence that office-based counselling increases use is not consistent among studies [10][11][12]. There are few studies on the effectiveness of office-based counselling for individual elements. Where such studies are available, they have been noted.

Given the evolving nature of evidence and changing recommendations, the Greig Health Record is meant to be used as a guide only. Regular updates to the statement and tool are planned.

Agreement amongst major guidelines

The following outlines the consensus available amongst each of the above guidelines. There is agreement on the need for a periodic health examination. Immunizations are uniformly recommended, although details are not consistent. There should be a physical examination in which height, weight, body mass index (BMI) and blood pressure are measured, and the stage of sexual maturity assessed in the adolescent. General anticipatory guidance is recommended, and specific counselling is recommended for healthy diets and seatbelt and helmet use. Counselling for alcohol and drug avoidance in specific activities is uniformly recommended. Sexually active females are advised to have cervical cancer and chlamydia screening.

Template layout

In the Greig Health Record, checklist templates are divided into three age ranges, 6 to 9 years, 10 to 13 years and 14 to 17 years inclusive. Headings for sections include weight, height, body mass index; psychosocial history and development; nutrition; education and advice; specific concerns; examination; and assessment, immunization and medications. While pages were divided arbitrarily into early, mid and late groupings, it is important to remember that children develop at different rates and screening questions should be tailored to the individual [13]. For example, it may be appropriate to discuss pubertal development with some 8 or 9 year-olds, especially girls, and not appropriate for their less mature peers.

Included with the checklist tables are three pages of selected guidelines and resources related to preventive care visits. The second of these pages focuses on injury prevention and, Internet resources and is designed for easy copying as a handout for patients and parents. The elements on the checklist are labelled with a star or stars to indicate the page location for related materials.

Template use, visit structure, and confidentiality

In the absence of compelling data, the present statement recommends that visits occur every one to two years based on a consensus recommendation. This interval is in common use and is recommended for obtaining height and weight measurements [14][15]. The American Academy of Pediatrics (AAP) (Bright Futures) and the American Medical Association (AMA) recommend yearly preventive health visits, but other guidelines do not specify frequency as the recommendation is not evidence-based [4][8][16]. In healthy younger children, there is some evidence to suggest that reducing the number of health promotion visits does not result in adverse outcomes (17). In the United Kingdom, a minimum of two visits is recommended: one at school entry and another for immunization at age 13 to18 years [18][19].

It is important to remember that the preventive heath visit is not the only opportunity to address prevention. Also, not all the elements in each section need to be covered at each visit. Clinicians are expected to use their own discretion as to the topics and timing of discussions with each patient.

It is important to consider and counsel on special issues pertaining to the adolescent [20]. It may be useful to review references on interviewing and examining adolescents [21]-[23]. It is generally recommended that at least part of the visit with the adolescent be conducted in private, with parents or guardians excused. Confidentiality is central to a successful therapeutic relationship [24]. While there are variations among provinces/territories, under Canadian Common Law minors can give informed consent to therapeutic medical treatment, provided they understand and appreciate the proposed treatment, attendant risks and possible consequences [21][25][26]. It is important that the adolescent understand the scope and limitations of this confidentiality, and that exceptions exist in cases of homicidal or suicidal ideation and emotional, physical or sexual abuse [24].

Care of the adolescent involves developing autonomy and responsibility in health care issues and transitioning from child-centred to adult-oriented health care. Both processes are particularly important for adolescents with special needs. The Canadian Paediatric Society (CPS) provides a helpful statement for guidance with these patients [27].

Measurements: Height, weight and BMI

A recent collaborative statement from the Dietitians of Canada, the Canadian Paediatric Society, The College of Family Physicians of Canada and Community Health Nurses of Canada, recommends the use of the World Health Organization (WHO) growth charts in children and adolescents [28]. Previously, growth charts from the US Centers for Disease Control and Prevention (CDC) for year 2000 were recommended for assessing and monitoring the growth of Canadian children [15][29]. The WHO charts for children 5 years and under display standards for growth under optimal conditions, and thus are considered superior to the CDC's population-based charts [30]. The WHO has also developed charts for children and youth aged 5 to 19 years to align with the younger group's charts (31). Although these charts are not based on population studies with growth under optimal conditions, they too are superior to the CDC's charts. They correct for the influence of rising obesity rates and they align with the younger group's charts as well as adult BMI cut-offs for overweight (>25 kg/m2) and obese (>30 kg/m2) [28].

Measurement of BMI is recommended as the most accurate gauge of appropriate weights for height and for the diagnosis of obesity. BMI for age charts from the WHO assist in determining percentiles. Note that for children over 10 years of age, BMI and not weight for age is recommended for plotting. Cut-offs are defined for underweight (< 3rd percentile), overweight (85th to 97th percentile) and obese (>97th percentile) [28].

Childhood obesity is associated with health problems in children and is a risk factor for adult morbidity and mortality [32]-[34]. Reviews of evidence for the prevention and management of childhood obesity are available [32][35][36], as are a practical guideline for managing obesity from the Ontario Medical Association Child Health Committee [37], and a clinical practice guideline from Obesity Canada [38]. It is important to note that evidence for effective primary care interventions is insufficient, although motivational interviewing shows promise [38]-[41].

Family history, risk factors and allergies

A small area for family history has been included on the top left-hand corner of the template to assist in identifying children at risk for conditions such as mood disorders, cardiovascular disease and diabetes [42][43]. Other risk factors and allergies can also be recorded here.

Psychosocial history and development

School and activities, peer relationships, family relationships

The social history of younger children should focus on family structure and dynamics, discipline issues, school performance and enjoyment, extra-curricular activities and peer relationships including bullying. The focus of health visits shifts as the child matures. Discussions are tailored to the child's age and maturity and consider anticipated changes. It is important to discuss the changing nature of the adolescent's relationships with peers and family, and to inquire about school, work and social groups. The HEADSSS (Home, Education and Employment, Activities, Drugs and Dieting, Sexuality, Suicide and Depression, Safety-violence and abuse) questionnaire is a guide for psychosocial interviewing of adolescents and is included in the template resource pages for reference [21].

Mental health

Adolescence is a time of emotional changes, peer pressure and risk of substance abuse, depression, anxiety and suicide. Anticipatory guidance should be given to the pre-adolescent as well as to older children. Most guideline-producing organizations, including the American Academy of Paediatrics (AAP), the American Academy of Family Practice (AAFP) and the American Medical Association (AMA), recommend asking about emotional health [2][42][44]-[46]. The United States Preventive Services Task Force (USPSTF) recommends screening for major depressive disorder (MDD) in adolescents (grade B) provided that systems for diagnosis, treatment and follow-up are in place. For pre-adolescent children (aged 7 to 11 years) there is insufficient evidence to make a recommendation [45]. As depressive disorders are present in 1to 2% of children in this age group, health care providers should be aware of associated symptoms and behavioural issues [47].

The USPSTF recommends the Patient Health Questionnaire for Adolescents (PHQ-A) and the Beck Depression Inventory-Primary Care version (BDI-PC) as effective tools for screening [45]. Other detailed guidelines for interviewing are also available [42][48]. The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit is particularly useful [47]. There is good evidence that primary care intervention in depression is helpful [45][49]. The use of cognitive behavioural therapy and/or interpersonal psychotherapy to prevent of depression in high-risk children and youth shows some promise [50]. The CPS website has an extensive directory of mental health screening tools available for members [51].

Body changes

The physical changes of puberty should be addressed and anticipatory guidance given. Assessment of sexual maturity is included in the physical examination. For easy reference, Sexual Maturity Rating (SMR) tables have been included in the template resource pages. Although age ranges have been included, it is recognized that there is considerable normal variation outside of the ranges given [52]-[54]. Precocious puberty refers to the appearance of physical signs of puberty before 9 years of age in boys, and before 7 or 8 years in girls. It is proposed by some that in some ethnic groups, the appearance of breasts and pubic hair may be normal as early as 6 years of age [55]; although there is considerable debate and concern about missing significant pathology [56]. One suggestion is

that girls who have both breast and pubic hair development at age 7 or 8 should have a review of growth and history and a bone age evaluation for height prediction and to help identify those in need of further testing [57].

Sexual health

Sexual health in the adolescent includes many factors that influence sexual development (both physical and psychosocial), sexual function and reproductive health. These topics must be addressed with sensitivity. Discussions can range from contraception to sexual orientation [58], from dating safety and abusive relationships to sexually transmitted infections. For sexually active adolescents, one must initiate counselling and screening as for young adults.

The USPSTF recommends intensive behavioural counselling in sexually active adolescents to prevent sexually transmitted infections [59]. Safer sex counselling for risk reduction is recommended as there is good evidence that counselling for condom use in adolescents decreases the incidence of sexually transmitted infections [60]. A table of prevention counselling topics is included resource pages of the template, summarizing strategies recommended by the Public Health Agency of Canada [61] and the CDC [62] in their sexually transmitted infection guidelines. Counselling about contraception [63] and anticipatory counselling about folic acid [64] are recommended by the Society of Obstetricians and Gynaecologists of Canada for all females in their childbearing years.

Screening sexually active youth is recommended as follows:

- Cervical cancer screening has been recommended to begin within three years of onset of vaginal sexual activity [65]; however, a recent evidence-based recommendation from the American College of Obstetricians and Gynecologists updates cervical cancer screening. For women under 21 years there is good evidence to omit cervical cytology screening. In adolescents and young women, HPV infections and dysplasia are likely to resolve spontaneously and risk of cancer is low [66].
- Persons under 25 years of age are at highest risk for chlamydial and gonococcal infections [67]. Chlamydia screening in females is recommended based on a grade A level of evidence. There is insufficient evidence to make a recommendation for males [68]. While the USPSTF reports insufficient evidence to recommend a screening frequency (68), the CDC recommends screening adolescent females annually [62].
- The USPSTF recommends gonorrhea screening in communities with a high prevalence of gonorrhea [3].
- HIV and syphilis screening is strongly recommended for specific high-risk groups [69][70].
- Physicians should screen all sexually active patients for high-risk behaviours [71], and recognise that disease prevalence changes and varies among communities.

A summary of the USPSTF screening recommendations is summarized on the reverse side of the tool [72].

The specifics of counselling and screening for pregnant teens are beyond the scope of this document. A summary of the evidence-based recommendations is available from the American Academy of Family Physicians [73][74].

Menstrual issues

Dysmenorrhea is the most common gynecologic complaint among adolescent females [75]. As well, it is a leading cause of absenteeism from school and work for this age group [76]. Disorders of menstruation, including dysfunctional uterine bleeding and amenorrhea, are significant health issues that adolescent females are often reluctant to discuss with health care providers [77]. Menstruating adolescents should be screened for risk factors associated with iron deficiency [78]-[80].

Testicular self-examination

There is evidence to recommend against counselling for testicular self-examination or clinical examination, in individuals of average risk, in light of the low incidence of testicular cancer and favourable outcomes in the absence of screening [3][81].

Breast self-examination

Teaching breast self-examination is not recommended in adults between 40 to 70 years of age. There is fair evidence of no benefit and good evidence of harm in the form of increased physician visits and benign biopsy results. For women under 40 there is little evidence on which to base a recommendation; however the very low incidence of breast cancer in this age group would make the net risk of harm more likely [82].

Nutrition, Supplements, and CAM, Eating Disorders

Healthy choices

The importance of nutrition in the health of children is readily appreciated [44]. Clear evidence exists for diet as a crucial factor in the causation of coronary artery disease, and there is growing evidence for nutrition playing a role in some cancers, hypertension and diabetes. Most clinicians recommend lowering saturated fats and consuming ample amounts of fruits, vegetables, whole grain cereals and legumes in order to reduce chronic diseases [83]. However, guidelines for nutrition requirements are not as readily available for older children as they are for infants and toddlers [84].

Methods to evaluate the quality of nutritional intake by children and youth can be helpful when questions arise about the healthfulness of eating habits [85]. *Canada's Food Guide* is a well known standard reference [86]. The periodic health visit is an opportunity to discuss healthy food choices for meals and snacks. Eating dinner at home with the family present is associated with better diet quality in children and adolescents [87][88]. Good choices for meals are not always accompanied by healthy choices at other times; the quality of meals eaten outside the home should also be addressed [89].

The adolescent female requires particular attention with regard to nutrition. Calcium intake, vitamin D and weight-bearing exercise, among other factors, influence bone mass accretion in adolescence, which in turn is directly related to adult bone mass [83][90]-[93]. Dietary iron intake should be evaluated in adolescents with heavy menses. Anemia is generally recognized as the main nutritional problem in adolescent girls worldwide [83].

Supplements and complementary and alternative medicine (CAM)

Physicians should ask about the use of vitamins, other supplements and alternative health products and therapies. Regarding supplements, the WHO recommends supplements for specific nutrient deficiencies but suggests that using food sources is important for making sustainable corrections for dietary deficiencies and healthy eating should be promoted [83].

Other supplements used by adolescents may include performance-enhancing products such as DHEA (dehydroepiandrosterone), creatine, protein supplements and anabolic steroids [94].

The definition of complementary and alternative medicine adopted by the Cochrane Collaboration is "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period" [95]. It can include herbs, homeopathic medicines, acupuncture, energy healing, yoga, special diets and biofeedback techniques [94][96]. Adolescents use herbs and dietary supplements more frequently than any other form of CAM [94][97].

The rate of CAM use is approximately 20 to 40% in healthy children and more than 50% in children with chronic, recurrent or intractable conditions [96][98]. In certain subgroups, such as street youth and those who have suffered relapses or other setbacks, rates approach 70% [96][98].

Physicians need to be aware of, enquire directly about and promote open discussion about CAM use (96). Possible interactions with prescription medications make it important to inquire about CAM use [96][99][100]. As with conventional therapies, safety of CAM products in adults does not ensure the same in children and adolescents [100].

Body image / dieting

Eating disorders, disordered eating and dieting can be addressed by inquiring about body image, self-esteem, desire to change weight and foods eaten. It is important to ask about weight control behaviours and obsessive thinking about food, weight, shape or exercise [101][102].

Health care providers should be aware that weight-related problems, including obesity, eating disorders, and disordered eating, have risk and protective factors in common. Therefore sensitivity to this information is important in the prevention of weight-related problems [103].

Education and advice

Behaviour and family issues

Physical activity: Regular daily exercise for children is key for maintaining physical health and reducing childhood obesity [32][104][105]. Being physically active has positive effects on self-esteem, quality of life and quality of peer relationships, and may have a protective effect against adult alcohol use and progression to other illicit drugs [106][107]. In adults, the effectiveness of physical activity in reducing the incidence of cardiovascular disease has been established [108]. Establishing good habits in childhood may lead to increased physical activity as adults [109]. Counselling with written materials can modestly increase physical activity [7].

Electronic media-TV / Internet / hearing protection: Education surrounding television and electronic devices is recommended. Limits need to be placed on duration, location and types of exposure [107][110][111]. Increased sedentary behaviour is a risk factor for overweight and obesity in children [105][112][113].

Physicians make a positive impact on children's television viewing habits. There is a relationship between watching violent television programmes and violent behaviour; a relationship between excessive television watching and obesity; and, watching certain programs may encourage irresponsible sexual behaviour [110]. Children often have access to the Internet both at home and school. Parents and children need to know basic rules for safe use of the Internet [110][114]. Parents can also be educated about how to find accurate health information on the Internet [115].

The periodic health visit is an opportunity to speak with patients about using ear protection for very loud activities such as rock concerts and about keeping the volume turned down on personal music devices. Using appropriately fitting earbuds or earphones is helpful [116]. Permanent hearing loss is related to the loudness and the duration of exposure. Rock

concerts and personal music players can reach an intensity of 110 to 120 dB [117]. The upper limit recommended for occupational noise exposure is 85 dB [118]. Studies show that many adolescents suffer permanent hearing loss due to excessive noise from leisure activities [119].

Sleep Issues: Sleep problems arise in all age groups. Disturbed sleep may be indicative of psychosocial issues or other medical conditions, such as obstructive sleep apnea [120][121]. It is worthwhile to ask about sleep habits, daytime somnolence and issues that may arise from disturbed or disruptive sleep patterns such as reduced concentration and irritability. There is a normal change in sleeping patterns during adolescence [122]. Caffeine use has detectable effects on sleep [123]. Poor sleep has significant negative effects on academic performance in adolescents [124]. Adolescents require 9 to 9 ½;; hours of sleep per night [125][126], but the actual mean sleep time for this group is significantly less [127].

Effective discipline: Age-appropriate anticipatory guidance can be given to parents for discipline issues. It is important to emphasize that discipline includes providing encouragement for positive behaviours and clear, consistent communication of limits and rules. Parent handouts on effective discipline for younger children are available from the CPS [128].

Injury prevention and safety

Injury prevention counselling has been shown to reduce some risk-taking behaviours. Counselling is most effective if multidisciplinary interventions are implemented [7][10][12]. To this end, sharing Internet resources on safety with parents and patients may be helpful.

Helmet safety: There is good evidence to support the use of bicycle helmets, with studies showing an overall decrease in the risk of head and brain injury by 65%-88% [129]-[131]. One study showed that office-based counselling results in a slight increase in use of bicycle helmets, while other studies demonstrated that office-based bicycle helmet counselling was not more effective than the standard of care [10]-[12]. Community-based intervention programs show a positive impact on bicycle helmet use [132]. Legislative interventions are also clearly effective in reducing head injuries [133][134] but only 6 of our 13 provinces and territories have bicycle helmet legislation [135]. Thus, an emphasis on a multi-disciplinary approach to counselling, including community education, is recommended [10] [11].

Vehicle safety: There is good evidence for the use of seatbelts for children aged 8 and older and for the use of booster seats for children between the ages of 5 and 7 [136]-[138]. In Canada, there is considerable variation in booster seat legislation. Some provinces have laws requiring booster seat use until 8, 9 and even 10 years while others make no recommendation [139]. Based on a systematic review of randomised controlled trials, there is strong evidence to support that counselling results in a modest increase in seatbelt use [12][140][141]. Physicians should counsel parents regarding graduation to seatbelts, especially to avoid premature graduation for smaller children [137][141][142]. Guidelines are available from Transport Canada [143] Safe Kids Canada [144] and the CPS [145].

Driving safety should be discussed [146], particularly related to being in a motorized vehicle (including watercraft and snowmobiles) as a driver or passenger while under the influence of alcohol or drugs [7][147]. There is fair evidence for the negative effects of driving under the influence of marijuana [148]. In contrast to driver education training programs, graduated licences appear to be effective in crash prevention [147][149]-[151]. There is good evidence that graduated licensing programs reduce the crash risk for young drivers by approximately 20-40% [152]. Contributing factors to teen driver crashes and injuries are listed in a table in the template resource pages.

The CPS and AAP recommend restricting the operation of all-terrain vehicles and snowmobiles to persons 16 years or older; there is strong evidence to support that operators under 16 years of age are at significant risk of sustaining serious head, brain, pelvic or spinal cord injuries (153). Physicians should also counsel parents that children should not ride as passengers on ATVs or snowmobiles [154][155].

Violence and firearms: Canada's youth mortality from firearms is one of the highest in the world [156][157]. Physicians are not accustomed to routinely discussing firearms and violence. Counselling about firearm safety is not effective, but fair evidence exists for firearms in the home increasing the risk of unintentional injury [156]. Parents can take an active role by reducing access to firearms, including removing them from the home [158].

Trampoline safety: Trampolines are a high-risk source of injury. Data from the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) show that the majority of trampoline injuries occur in children aged 5 to 14 years. While the most common injury is upper limb fractures, severe injury can result from cervical spine trauma. Many trampoline injuries occur when there is more than one person on the jumping surface and supervision is inadequate or absent. The CPS, AAP and Safe Kids Canada recommend the elimination of all trampolines in the home environment and no participation for children under 6 years of age [159].

Water safety: There is insufficient evidence that swimming lessons and water safety education prevent injury [2]. There is evidence that swimming lessons improve swimming ability and water recovery [160]-[162]. However, there is no clear evidence that swimming lessons prevent children from drowning or near-drowning. Active supervision and pool fencing are the most important preventive strategies for drowning and near-drowning; children and adolescents should be counselled to never swim alone [163]-[165]. Swimming and swimming

lessons can be encouraged and promoted for physical activity. Swimming skills are learned most efficiently beginning at about 5 years of age [166].

Sun safety: Sun exposure in childhood is a major risk factor for adult melanocytic and non-melanocytic skin cancers [167] [168]. Patients and families need education about ultraviolet light exposure, both from sunlight and from tanning salons. Determination of the effectiveness of interventions in health care settings requires further study [169].

Workplace safety: For adolescent workers, occupational injury and illness are largely preventable. Physicians can play a crucial role in prevention by advising them of common workplace dangers [170]. It is important to note that younger children may also be exposed to workplace hazards, especially in family businesses such as farming and fishing operations. It has been shown that a workweek of 20 hours or more is associated with emotional distress in adolescents [171].

Environmental hazards: Evidence for hazards posed by exposure to toxins in the environment is evolving. Children are particularly at risk [172]. Physicians should be aware of available resources, some of which are listed resource pages of the template. A review of current evidence for the effects on children of the following hazards is available: environmental tobacco smoke, lead, methylmercury, polychlorinated biphenyls, dioxins, certain pesticides, aeroallergens, ambient air toxicants, chlorination disinfection by-products, magnetic fields, radiofrequency radiation, residential proximity to hazardous waste disposal sites, and solvents [173]. There is good evidence for second-hand smoke as a cause of asthma, worsening asthma and lower respiratory tract infections [174][175]. Concern also exists about levels of exposure to DEET in insect repellents [176]-[178].

Smoke detectors: There is fair evidence that smoke detectors save lives. Families should be counselled to ensure that smoke alarms are properly installed and checked regularly [7] [140].

Other safety topics: Clinicians may wish to include other safety topics in discussions with patients and parents. A list of possible topics is included in the template resource pages. Parents can be directed to the Canada Safety Council website [179], Safe Kids Canada [180] and the CPS Keeping Kids Safe resources [181].

Traffic and pedestrian safety, winter safety and playground safety should be addressed with the younger child. Playground safety information can be obtained from the CPS and Safe Kids Canada [180]. Safe road-crossing should be discussed [7]. Where appropriate, farm and rural safety can be discussed.

Children's curiosity puts them at risk. Discarded needles, syringes and condoms can be found in the child's environment including in parks and schoolyards. The CPS advises parents to teach children about the risks of handling needles and syringes and makes recommendations for management of needle stick injuries [182].

Preparing children for situations in which they need to show initiative can be part of the periodic counselling. Young children can be taught to memorize their phone numbers and addresses and given simple rules to follow for various situations such as being lost, in danger or home alone. These are more than the over-simplified "never talk to strangers" rule [183][184].

Bullying including cyber-bullying is an important topic to discuss with all school-age children. Although prevalence varies from study to study, bullying is experienced by a significant number of children either as perpetrator or victim (185,186). Both bullies and their victims suffer consequences to both psychological and physical well-being [186][187][188].

Sports and recreation counselling topics will depend on the activities the child or youth is involved in, such as skiing, hockey, canoeing or tobogganing.

For the older child, the periodic health visit presents an opportunity to discuss safety and making choices especially in social settings. Dating safety should also be addressed [189]. The Kids Help Phone website is an excellent general resource with numerous website links and topics for youth about safety and much more [190].

Other

Substance abuse: Most of the major guideline-producing organizations recommend screening and counselling for tobacco use, under-age drinking and illicit drug use. Physicians should advise adolescents to avoid binge drinking and smoking; however, there is insufficient evidence to recommend for or against routine screening for drug use [191]. Issues such as family and peer relationships, academic progress, extracurricular activities, self-esteem and acceptance of authority should be part of a routine history with patients 8 years of age and older. Determining a patient's psychosocial history may reveal potential risks and/or preventive factors for substance abuse [192].

Smoking has a negative effect on lung function in children [193]. Smoking in adolescence has shown to be an important predictor of continued smoking into adulthood. It is important that physicians address strategies for quitting if the patient is already a smoker [194]. There is conflicting evidence for the effectiveness of counselling about tobacco and alcohol use. Some studies show strong evidence for the effectiveness of counselling [43][195], while others show ineffectiveness or worse [7]. One study reported that screening and counselling for risky behaviours in adolescents were more effective when health care workers had proper training (196). Also, a multidisciplinary approach to awareness about alcohol and tobacco

use is an important component of prevention [194]. However, the USPSTF concludes that there is insufficient evidence to make a recommendation in adolescents [3].

Abuse: Maintaining vigilance for signs and symptoms of abuse is recommended by the American Academy of Pediatrics, the American Academy of Family Practice and the American Medical Association. Reporting cases of suspected maltreatment is mandatory in all of Canada except the Yukon Territory [197]. Education of children for what constitutes abuse and what they can do about it is also recommended [198][199][200].

However, the use of specific screening tools in older children is not recommended. The Canadian Task Force on Preventive Care concludes that there is fair evidence to exclude screening procedures for abuse prevention [201]. The US Preventive Services Task Force found that no trials of the effectiveness of screening in a health care setting have been published, and interventions for older children have not yet been shown to be effective [202].

Dental care and fluoride: Professional dental care, including fluoride application and the selective use of sealants has been clearly shown to reduce dental caries. Brushing and flossing are recommended for hygiene and aesthetics, reduction of gingival disease and cavity prevention [203]. Fluoride supplementation should be discussed in areas where fluoride is not present in sufficient amounts in the water supply [204].

Specific concerns

A section has been included to make note of specific concerns as illnesses and other issues are commonly raised at the periodic health examination [205]. Space is sufficient only for a notation of the issue and a direction to look elsewhere in the patient's chart for details.

Physical examination

Consensus opinion supports the inclusion of height, weight, blood pressure and visual acuity screening as part of the physical examination. Headings for other examinations have been included as reasonable for the purpose of case-finding.

Blood pressure: The AMA recommends yearly blood pressure measurements [44]. The USPSTF has concluded that evidence is insufficient to recommend for or against routine screening for high blood pressure in children and adolescents for the reduction in risk of cardiovascular disease. However, blood pressure measurement to detect early, treatable causes of secondary hypertension is recommended by the AAP, the AMA and the American Heart Association [206]. Guidelines for the proper measurement of blood pressure and diagnosis of hypertension are available [207].

Visual acuity screening: Visual acuity in this age group should be assessed at each periodic health visit and whenever complaints occur [208].

GU examination and sexual maturity rating: Genitourinary (GU) examination and female breast examination should be approached with clear ethical standards and sensitivity; a guideline is available from the Canadian Paediatric Society [209]. A sexual maturity rating is recommended by most guidelines for adolescents [8]. An excellent resource for the assessment of delayed puberty, precocious puberty and short and tall stature is available in chapter 8 of Neinstein *et al.* [210].

Scoliosis: Screening for idiopathic scoliosis in asymptomatic adolescents is not recommended by the USPSTF or the CTFPHC [211]. There is evidence that asymptomatic individuals have a mild clinical course and interventions, such as braces and exercise, may not improve back pain or quality of life. The potential harms are unnecessary medical evaluations and adverse psychological effects, especially related to wearing corrective braces. The USPSTF also states that clinicians should evaluate scoliosis when it presents as a symptom or is found incidentally [212]. Screening is still recommended by the American Academy of Orthopaedic Surgeons [213] and the AAP, but with little evidence to support this position [214][215].

Assessment, immunization and medications

Laboratory investigations

Apart from a rubella titre for adolescent females, evidence does not support routine laboratory investigations [3][79][195].

A high index of suspicion should be maintained for iron deficiency in menstruating females. Those with dietary, ethnic or other risk factors should be considered for screening. When screening for iron deficiency, ferritin, not haemoglobin, is the most sensitive and specific measurement [78]-[80]. It is important to remember that ferritin is an acute phase reactant and as such, it may be elevated in certain pathologic states.

Sickle cell screening in at-risk populations is recommended for newborns, but insufficient evidence exists for a recommendation on hemoglobinopathy screening in older children and adolescents [216][217].

Lipid and plasma glucose screening should be performed on overweight or obese children over the age of 10 [38]. Evidence for routine screening is lacking [218].

Immunization and TB screening

Immunization recommendations and reminders are included as per current guidelines from the Public Health Agency of Canada's National Advisory Committee on Immunization (NACI) [219]. Vaccination schedules vary somewhat among provinces and territories. In this age group, the periodic health visit is a perfect opportunity to ensure that immuniza-

tions, including the annual influenza vaccine [220], are up-to-date, and to discuss the need for travel or newer vaccines as they become available.

NACI guidelines recommend a routine childhood varicella immunization for healthy non-pregnant individuals. Children, adolescents or adults with a reliable history of varicella disease need not be vaccinated. For children 12 months to 12 years of age with an unknown or negative history of prior varicella infection, a single dose of vaccine is recommended. For persons aged 13 years and over, either immunization (two doses 4 to 6 weeks apart) or performing serologic testing is recommended, since up to 80% will be immune despite a negative history [221].

Tuberculosis screening should be limited to high-risk groups. Although active TB is uncommon among Canadian-born children, Aboriginal populations and recent immigrants are at increased risk [222].

A routine meningococcal conjugate vaccine dose in early adolescence is currently recommended even for those vaccinated in the first two years of life. The adolescent dose can be provided using a monovalent C conjugate vaccine or a quadrivalent conjugate meningococcal vaccine for A, C, Y and W135. The quadrivalent vaccine should be given to children 2 years of age and older with primary antibody deficiencies [223][224].

A vaccine for human papillomavirus (HPV) is available for girls and young women aged 9 to 26 years. NACI has recommended vaccination for all girls aged 9 to 13, as well as for females aged 14 to 26 (if they are not already vaccinated). This includes females who are already sexually active as they are unlikely to have been exposed to all four of the HPV types covered by the vaccine [225][226]. Note that vaccination is not a substitute for cervical cancer screening [227].

Summary

The Greig Health Record is an evidence-based health supervision guide for clinicians caring for children and adolescents aged 6 to 17 years. It is meant to provide a template for periodic health visits and anticipatory guidance. Given the evolving nature of evidence and changing recommendations, the Greig Health Record is meant to be used as a guide only. Regular update to the statement and the tool are planned. It is important to remember that the periodic heath visit is not the only opportunity to address prevention. It is expected that physicians will use their discretion in selecting topics to discuss with each patient and the timing of the discussions.

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