1. Task Number	2. Investigator's ID	EPIDEMIOLOGIC INVESTIGATION REPORT
091021HCC2091	9082	

3. Office Code	4. Date of Accident YR MO DAY	5. Date Initiated YR MO DAY
810	2007 09 07	2009 10 23

6. Synopsis of Accident or Complaint UPC

The boy was smothered while sleeping face down and up against a bumper padding inside a crib at his mother's cousin's home. The babysitter gave him a 4 oz bottle at 5 a.m. and at 7:10 a.m. she found him unresponsive, bluish-purple and cold to the touch. His body was face down with his face on a bumper pad that was pulled down like he was snuggling with it. Autopsy determined he died of "positional asphyxia while laying face down in thick soft crib bumper pad bedding at the corner of the crib."

7. Location (Home, School, etc)	8. City	9. State
1 - HOME	FLANAGAN	IL

10A. First Product	10B. Trade/Brand Name	10C. Model Number
1543 - Cribs	UNKNOWN	UNKNOWN

10D. Manufacturer Name and Address
UNKNOWN

11A. Second Product	11B. Trade/Brand Name	11C. Model Number
1542 - Baby Mattresses Or Pads	UNKNOWN	UNKNOWN

11D. Manufacturer Name and Address
NONE

12. Age of Victim	13. Sex	14. Disposition	15. Injury Diagnosis
205	1 - Male	8 - Death	65 - Anoxia
16. Body Part(s) Involved	**17. Respondent**	**18. Type of Investigation**	**19. Time Spent (Operational / Travel)**
85 - ALL OF BODY	3 - 2nd Hand Info Only	2 - Telephone	15 / 0

20. Attachment(s)	21. Case Source	22. Sample Collection Number
9 - Multiple Attachments	14 - Death Certificate	

23. Permission to Disclose Name (Non NEISS Cases Only)

○ Yes ● No ○ Verbal ○ Yes for Manuf. Only

24. Review Date	25. Reviewed By	26. Regional Office Director
12/09/2009	9001	Dennis R. Blasius

27. Distribution	28. Source Document Number
Blasius, Dennis; Edwards, Patricia	0717054853

SUMMARY

This investigation was initiated from a death certificate. The 5 month old boy from Wenona, Illinois was smothered while sleeping face down and up against a bumper padding inside a crib at his babysitter's home in Flanagan, Illinois.

PRE-INCIDENT

The boy was born on April 6, 2007 in Pontiac, Illinois. He was a full term baby at 38-39 weeks. He weighed 5-pounds and 11-ounces. He was 17 1/2-inches long.

At five months old, the boy weighed 11 pounds and 12 ounces, and was about 22-inches long.

On September 6, 2007, at approximately 2:30 p.m., the five-month old boy, who weighed 15.4 pounds and was 25-inches long, was brought to the mother's cousin's 2-story rented farm house with an unfinished basement in Flanagan, Illinois. The babysitter lives there with her boyfriend and her six year old daughter. The boy is taken there every Thursday to give the mother time to sleep well.

The babysitter gave him a bath before putting him to sleep in his crib in the first floor bedroom while she slept on the sofa because she did not have a baby monitor. The temperature in the home was 78 degrees.

On September 6, 2007, at about 11:30 p.m., the babysitter's boyfriend returned from work and checked on the boy. He was a little fussy, but when he turned on the mobile, he was fine.

On September 7, 2007, at approximately 5:00 a.m. the babysitter gave the baby four ounces of baby formula, that the police later determined had not expired, with water.

The boy's crib contained a mattress with a fitted sheet, a cloth bumper that extended the entire interior of the crib, a large blanket hanging over the crib and a portion of the blanket under the boy's head, a small thin blue blanket, a musical toy, and a comforter matching the fitted sheet.

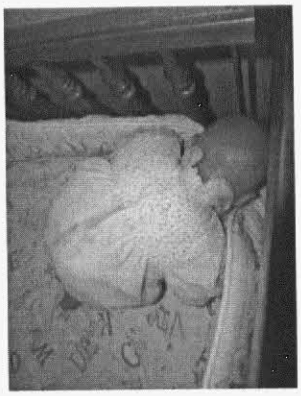
INCIDENT

On September 7, 2007, at about 7:10 a.m., the babysitter's daughter woke up her mother. The babysitter checked on the boy, found him laying on his stomach, turned him over, and found him unresponsive, purple in color, and cold to the touch. She

yelled and her boyfriend responded. When he entered the bedroom he saw the boy was blue and the aunt was calling 911. Police arrived and called for paramedics. When the paramedics arrived, they found no signs of life.

POST-INCIDENT

Later, the babysitter positioned a doll in the same position she found the boy for the police. She placed the doll on its stomach with the bumper pad pulled down like he was snuggling with it.



The babysitter later found a bottle of medication for the boy in his diaper bag that was used for Thrush. He was diagnosed with Thrush on August 9, 2007. The babysitter did not give the boy his medication because she was not aware of his condition.

The boy's parents lived in Wenona, Illinois with the boy.

The autopsy determined the boy died from "positional asphyxia while laying face down in thick soft crib bumper padding bedding at the corner of the crib."

Product information was not available from the coroner's office or police department; however, the police department did provide photographs.

PRODUCT IDENTIFICATION

Item #1: Crib

Brand/
Model: Unknown

Description:

Retailer/
Manufacturer: Unknown

Item #2: Bumper Padding

Brand/
Model: Unknown

Description:

Retailer/
Manufacturer: Unknown

SAMPLE COLLECTION - No sample collected.

ATTACHMENTS

Exhibit 1 - Coroner's Autopsy N-07-286
Exhibit 2 - State Police Case 4615-07-1048-9-1
Exhibit 3 - Sheriff's Incident 921721-07 & 921721-07A
Exhibit 4 - Hospital Reports, Infant 584555
Exhibit 5 - Contact Sheet

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OFFICE OF THE
LIVINGSTON COUNTY CORONER

REPORT OF POSTMORTEM EXAMINATION

COUNTY: LIVINGSTON

AUTHORITY: MICHAEL BURKE, Coroner

NAME: [redacted]

AUTOPSY #: **N-07-286**

SEX: Male

RACE: White

AGE: 5 Months

ADDRESS OF DECEDENT: 615 S. Chestnut
Apt. 12

CITY AND STATE: Wenona, Illinois

EXAMINED BY: J. Scott Denton, M.D.

DATE OF DEATH: September 7, 2007

TIME OF DEATH: 7:30 a.m.

DATE OF AUTOPSY: September 8, 2007

TIME OF AUTOPSY: 7:55 a.m.

EXTERNAL EXAMINATION:

The body is received clothed in a clean blue plastic diaper, with an accompanying blue clean baby blanket. Brought to the examination by an evidence technician within separate bags are a white crib bumper padding without fluid material or staining, multiple crib bedding materials, a blue blanket with a small brown marginal stain, a clean yellow onesie sleeper outfit, and a diaper with urine weighing 90 g. Assisting in the examination is William Belcher.

The body is that of a well-developed and well-nourished-appearing, white male infant, weighing 15.4 pounds (25th percentile for age), measuring 25.0 inches crown-heel length (25th percentile for age), with a crown to rump length of 17.0 in. The head, chest, and abdominal circumferences are 17.0 in., 16.5 in., and 15.0 in., respectively. The skin is cold. Rigor mortis is well-developed. Livor mortis is red and blanchable, evenly both anteriorly and posteriorly.

Skin nutrition, hydration, cleanliness, and turgor appear good. The scalp is covered by thin, blonde hair. The scalp is without evidence of laceration or hematoma. The posterior fontanel is closed. The anterior fontanel is slightly open, 0.4 x 0.4 in. The eyes are closed. The irides are blue. The sclerae and conjunctivae are clear without petechiae or congestion. The skeleton of the nose is intact. The nares are patent. The upper and lower palates are without teeth and are normal. The upper and lower frenula are unremarkable. The lips and oral mucosa are unremarkable. No foreign material is within the mouth. The tip of the tongue is unremarkable. The ears are unremarkable and clean. The anterior and posterior neck are unremarkable and clean without hypermobility or evidence of injury.

SD

NAME: [redacted] AUTOPSY #: N-07-286

The chest, abdomen, posterior neck, back, buttocks, anus, and upper and lower extremities are symmetrical and normally developed without evidence of injury. Genitalia appear normal male and circumcised. Both testes are palpated and descended within the scrotum. The fingernails are short and clean with mild cyanosis of the fingernail beds. The toenails are short and clean. The soles of the feet are unremarkable and clean.

EVIDENCE OF INJURY:

On the top of the left side of the head is a circular red impression mark with central petechiae, 0.5 x 0.5 inch, without underlying subgaleal hematoma.

INTERNAL EXAMINATION:

Body Cavities: The body is entered by a Y-shaped incision. The head is entered through an intermastoid incision. All organs are within their usual anatomic positions and relationships without abnormal fluid accumulation. No abnormal fluid accumulation is seen in the cranium. The pleural surfaces are smooth and glistening without petechiae. The midline abdominal panniculus is 1.0 cm thick.

Neck Organs: The anterior muscles of the neck are free of hemorrhage. The cartilages of the larynx and epiglottis are intact. The hyoid bone is intact. The mucosal surfaces are tan and free of obstruction. The tongue is unremarkable externally and on sectioning. The thymus gland weighs 29 g and pink and lobular without petechiae. Cut sections show unremarkable pink tissue exuding lymph fluid without abnormality.

Respiratory System: The right lung weighs 73 g. The left lung weighs 59 g. The lungs are normally formed, have normal vascular attachments, and diffusely soft and red-tan. Cut sections show red-tan congestion without infiltrate or fibrosis with normal anatomic features. Bronchi are unremarkable. The pulmonary vasculature attaches normally to the heart and is unremarkable.

Cardiovascular System: The heart weighs 39 g and is normally formed. The pericardium is intact. There is no effusion. The superior and inferior vena cava, aorta, and pulmonic arteries and veins attach normally to the heart. The right and left atria and ventricles are without hypertrophy, dilatation, or fibrosis. There are no atrial or ventricular septal defects. Sections of the myocardium are red-brown without fibrosis or discoloration. Coronary arteries pursue their normal courses and are without anomaly arising normally from the aortic ostia. The aorta follows its normal course through the thorax and abdomen without anomaly.

Hepatobiliary System: The liver weighs 241 g. The surface is smooth with sharp margins and is red-brown. Cut sections show soft, red-brown, congested tissue without fibrosis. The biliary tracts are unremarkable with approximately 3 cc of golden bile in the gallbladder without stones or anomaly.

Hemolymphatic System: The spleen weighs 19 g. The surface is soft, red, and smooth. Cut sections show unremarkable red pulp and follicles. There is no adenopathy. Sternal bone marrow is red and normocellular.

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NAME: [redacted] AUTOPSY #: N-07-286

Gastrointestinal System: The esophagus is unremarkable without fistula or erosion. The stomach contains approximately 10 cc of yellow, mucoid material without ulceration or hemorrhage with normal tan mucosa. The duodenum, small and large intestines, and appendix are unremarkable with soft, yellow, fecal material in the small intestine and soft, green, fecal material in the large intestine.

Genitourinary System: The right kidney weighs 24 g. The left kidney weighs 25 g. The surfaces are red-brown and smooth with normal lobulation. Cut sections show unremarkable cortices and medullae. The renal pelves, ureters, and urinary bladder are unremarkable. 1 cc of pale urine is seen. The mucosa is white. The prostate is unremarkable on sectioning.

Endocrine System: Examination of the thyroid, pituitary, pancreas, and adrenal glands is unremarkable externally and on sectioning.

Musculoskeletal System: The general musculature is tan without hematoma and normally developed. No fractures are identified internally or palpated externally. Specifically, there are no extremity, rib, or skull fractures.

Central Nervous System: The brain weighs 751 g and is normally formed and softened. The scalp is without laceration or hematoma. There is no subgaleal hemorrhage. The skull is intact with the anterior fontanel flat. The leptomeninges are normal. Spinal fluid is clear. There is no epidural, subdural, or subarachnoid hemorrhage. There is no optic nerve hemorrhage. The surfaces of the brain are symmetrical, normally developed, and soft. Serial sections of the cerebrum, cerebellum, and brain stem are normally developed for age without anomaly with appropriate cortico-medullary junction distinction. The vessels at the base of the brain, the cervical spinal cord viewed in the foramen magnum, internal palpation of the neck, and a section of thoracic spinal cord and vertebra are all unremarkable.

MICROSCOPIC EXAMINATION:

Sections of the lungs show congestion without pneumonia or fibrosis. Sections of the heart, spleen, bone marrow, liver, thymus, urinary bladder, pancreas, brain, adrenal gland, neck block, kidneys, intestines and stomach are without pathologic changes.

SPECIAL STUDIES:

1. Vitreous humor, blood, bile, and urine are submitted for toxicologic analysis (see report).
2. Tissue biopsies are submitted for histologic examination, as well as saved with a sample of gastric contents in a formalin stock bottle at the McLean County Coroner's office.
3. Total body radiographs are taken and reviewed without occult fracture identified.
4. A blood card standard is given to the Livingston County Coroner.
5. Photographs taken of the doll reenactment of the scene of death performed by the Illinois State Police Investigator are reviewed.

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NAME: [redacted]

AUTOPSY #: N-07-286

SUMMARY DIAGNOSES:

1. Pulmonary congestion and edema.

2. Circular impression mark on the top of the left side of the head, 0.5 inch, recent.

OPINION:

After consideration of the circumstances surrounding his death, a review of available medical history, and after post-mortem examination with ancillary studies and review of scene investigation photographs, the death of this 5-month-old, white male, [redacted] is due to positional asphyxia while laying face down in thick soft crib bumper padding bedding at the corner of the crib.

SD

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LIVINGSTON COUNTY CORONER

Scott Denton, MD

J. Scott Denton, M.D.
Forensic Pathologist

September 21, 2007

Date Signed

ILLINOIS STATE POLICE
Division of Forensic Services
Crime Scene Services Command
515 East Woodruff Road
Joliet, Illinois 60432

Crime Scene Report

Crime Scene Investigator	
Heather H. Hansen	

Requesting Department	Requesting Department Case Number	C.S.S.C. Case # / CAD Incident #	Classification
Livingston County Sheriff's Office 844 West Lincoln Street Pontiac, Illinois 61764	09-21721	4615-07-1048-9-1 AF/070907/002615	Death Investigation
Date, Time Notified	**Date and Time of Arrival**	**Weather**	**Temperature**
09/07/07 7:40 a.m.	09/07/07 9:20 a.m.	Clear	84^0 Outside
Evidence Transported to Laboratory	**Date and Time Received at Laboratory**	**Received by**	**F.S.C. Case Number**
N/A	N/A	N/A	N/A
Evidence Retained by Agency	**Date and Time**	**Received by**	**Other Laboratory**
#1 - #15	09/08/07 11:00 a.m.	Detective Dutko	N/A
Imaging	**Sketch**	**Laboratory Disciplines**	
Digital	Yes	Forensic Biology	

Victim: [redacted]
M/W, DOB 04/06/07
[redacted]

Witness: [redacted]
F/W, DOB 11/28/83
[redacted]

On 09/07/07 at 7:40 a.m., Crime Scene Investigator Heather H. Hansen was requested by the Livingston County Sheriff's Office to process a death investigation scene located at [redacted].

At 9:20 a.m., CSI Hansen arrived at the scene and met with Investigator Dutko of the Livingston County Sheriff's Office. Investigator Dutko related to CSI Hansen that the victim was being cared for by the witness in the witness' home. The witness stated that she fed the victim four ounces of baby formula at 5:00 a.m. At 7:00 a.m., when the witness checked on the victim, he was unresponsive and cold to the touch. The witness called "911." Officers arrived and summoned paramedics, who checked the victim for signs of life with negative results. The scene was secured until the arrival of the Livingston County Coroner and CSI Hansen.

Illinois State Police
Division of Forensic Services
Crime Scene Services Command

4615-07-1048-9-1
C.S.S.C. Case Number
07-20478
Requesting Agency Case Number

Crime Scene Report

The scene was photographed and examined by CSI Hansen.

The following observations were made at the scene: The scene consisted of a two-story farm house located on the east side of [redacted] and faced west. The residence was on the property of a farm and was being rented by the witness. The witness was the biological aunt of the victim. The residence consisted of a kitchen, a living room, a dining room, a bathroom, and one bedroom on the first floor. Three bedrooms were located on the second floor. The residence also had an unfinished basement. The temperature in the residence was approximately 78 degrees.

The victim was in the bedroom on the first floor, at the northwest corner of the residence. The bedroom had a twin bed along the south wall. The bed was covered in children's clothing. A rocking chair was just east of the end of the twin bed. A dresser was along the north wall and a crib was along the west wall. The victim was in the crib, face up, with his head to the north and his feet to the south. Both of the victim's arms were extended over his head and his feet and legs were extended straight. The victim was wearing a one-piece jumper with snaps down the front. CSI Hansen removed the jumper and diaper from the victim. The diaper was full of urine, but no feces. The crib had a mattress with a fitted sheet. The crib had a cloth bumper that extended the entire interior of the crib. A large blanket was hanging over the north side of the crib and a portion of the blanket was under the victim's head. A small, thin blue blanket was in the crib with a corner of the blanket on the victim's right knee. A musical toy was located across the south end of the crib on the interior. A comforter matching the fitted sheet was on the dresser. The witness stated that it was in the crib when she found the victim unresponsive. The comforter was collected.

CSI Hansen requested that the witness use a doll from the residence and demonstrate to CSI Hansen how the infant was found. The witness placed the doll in the corner of the crib face down, with the bumper that surrounds the crib, under the doll's mouth and nose. She stated that it looked like the baby was snuggling the bumper. CSI Hansen photographed the doll in the position the witness placed it in.

CSI Hansen examined the living room and dining room of the residence. CSI Hansen located the clothing the victim was wearing before being changed into the one piece jumper. CSI Hansen collected a pair of blue overalls and a white, short-sleeved, one-piece jumper. No stains or defects were observed on the infant's clothing. A baby bib was on the floor with unknown stains, CSI Hansen collected the bib. Nothing appeared disturbed in either room. Numerous toys and a baby swing were located; however, none of them had defects or unusual stains.

CSI Hansen examined the kitchen of the residence. A can of "Similac" formula was collected from the kitchen table. According to the expiration date, the formula was not expired. A bottle of "Nestle" water was also collected from the kitchen. The witness stated that she used the "Nestle" water to mix with the formula to prepare the

victim's bottle. A bottle with an off white liquid was collected from the refrigerator. A bottle of oral medication was on the kitchen counter with the victim's name. The bottle of medication was collected.

Nothing appeared disturbed or out of place in the kitchen.

CSI Hansen examined the bathroom on the first floor. A rolled-up, used, infant diaper was on the floor of the bathroom. The witness related that the diaper had been removed before the victim's bath the night before. The diaper was collected. Nothing appeared disturbed in the bathroom.

CSI Hansen examined the second level of the residence. Nothing appeared disturbed, and no infant clothing or belongings were located on the second level.

The victim was transported to the McLean County Morgue by personnel from the Livingston County Coroner's Office.

The following items of evidential value were collected, packaged, and marked from the scene by CSI Hansen, as indicated on the evidence receipt:

Exhibit #1	Sealed paper bag containing a bumper pad from the victim's crib.
Exhibit #2	Sealed paper bag containing a large Winnie the Pooh blanket from the victim's crib.
Exhibit #3	Sealed paper bag containing a comforter from the victim's crib.
Exhibit #4	Sealed paper bag containing a fitted sheet from the victim's crib.
Exhibit #5	Sealed paper bag containing a diaper recovered from the bathroom.
Exhibit #6	Sealed paper bag containing a bottle of oral medication.
Exhibit #7	Sealed paper bag containing a white and yellow one-piece sleeper recovered from the victim.
Exhibit #8	Sealed paper bag containing a diaper removed from the victim.

Illinois State Police
Division of Forensic Services
Crime Scene Services Command

4615-07-1048-9-1
C.S.S.C. Case Number
07-20478
Requesting Agency Case Number

Crime Scene Report

Exhibit #9	Sealed paper bag containing a bib from the floor of the living room.
Exhibit #10	Sealed paper bag containing a can of "Similac" formula recovered from the kitchen table.
Exhibit #11	Sealed paper bag containing a bottle of "Nestle" water.
Exhibit #12	Sealed paper bag containing an infant's blue overall outfit from the floor of the living room.
Exhibit #13	Sealed paper bag containing a white one-piece outfit with short sleeves.
Exhibit #14	Sealed paper bag containing a small blue blanket from the victim's crib.
Exhibit #15	Sealed paper bag containing a baby bottle with an off white liquid recovered from the refrigerator.

On 09/07/07 at 11:06 a.m., CSI Hansen departed the scene.

On 09/08/07 at 8:00 a.m., CSI Hansen arrived at the McLean County Morgue to attend the autopsy of the victim. The autopsy was preformed by Dr. S. Denton. The results of the autopsy will be the subject of a separate report by Dr. Denton.

On 09/08/07 at 11:00 a.m., CSI Hansen receipted Exhibits #1 through #15 to Detective Dutko at the McLean County Morgue.

The digital images captured were saved to an original CD. A copy CD of the digital images will be forwarded to the Livingston County Sheriff's Office, and the original CD will be maintained with the crime scene case file.

Illinois State Police
Division of Forensic Services
Forensic Sciences Command

CSSC Number: 4615-07-1048-9-1

Laboratory Case Number:

EVIDENCE RECEIPT, Cont'd.

Page 2 of 2

TYPE OR USE BLACK BALL POINT PEN ONLY; INSTRUCTIONS ON REVERSE

(1) Originating Agency Name: Livingston Co. Sheriffs Dept.

(2) Victim(s) Name(s): [redacted]

(3) Agency Case Number: 0921721

(4) Printed name of investigating case officer: Det. E. Dutko

(5) Printed name of the officer and agency delivering evidence: Tpr. H. Hansen #4615

(6) Lab Exhibit Number(s)	(7) CSSC Exhibit Number(s)	(8) Agency Exhibit Number(s)	(9)	(10) Evidence description (see instructions)
				(1) Bottle of Nestle water
				(1) Blue overall outfit
				(1) white one piece outfit
				(1) Small blue blanket
				(1) Baby bottle with formula

EVIDENCE CHAIN

(18) Attach pertinent case information, the case summary, and examination requests. **IMPORTANT:** List any communicable diseases of risk to lab personnel (e.g., hepatitis, TB, HTLV/LAV II, etc.)

(19) AFIS: Yes ☐ No ☐ Comments

(20) Lab Exhibit Number(s)	(21) CSSC Exhibit Number(s)	(22) Date	(23) Returned By (DFS Employee Signature)	(24) Released to (law enforcement representative signature and agency name if applicable)
	1 (Cont'd)		Tpr. H. Hansen #4615	E. Dutko #11 DUTKO

Illinois State Police
Division of Forensic Services
Forensic Sciences Command
EVIDENCE RECEIPT

SC Number: 615-07-1048-5

Laboratory Case Number:

Page 1 of 1

PE OR USE BLACK BALL POINT PEN ONLY; INSTRUCTIONS ON REVERSE

AGENCY DATA

(1) Originating Agency Name: LIVINGSTON COUNTY SHERIFFS DEPT.
(2) Agency Telephone: (815) 844-2774
(3) NCIC Number: IL0530000
(4) Agency Case Number: 0921721
(5) Send report to: DET. E. DUTKO
Agency address: 844 W. LINCOLN
City: PONTIAC
Zip Code: 61764
(6) Offense: Death Investigation
(7) County of Offense: LIVINGSTON
(8) Date Offense Occurred: 9/7/07
(9) Victim(s) Name(s), Sex, Race, DOB: [redacted] M/W 4/6/07
(10) Suspect(s) Name(s), Sex, Race, DOB:
(11) Printed name of investigating officer if different than (5) above:
(12) Printed name of the officer and agency delivering evidence: Tpr. Heather Hansen #4615

EVIDENCE INVENTORY

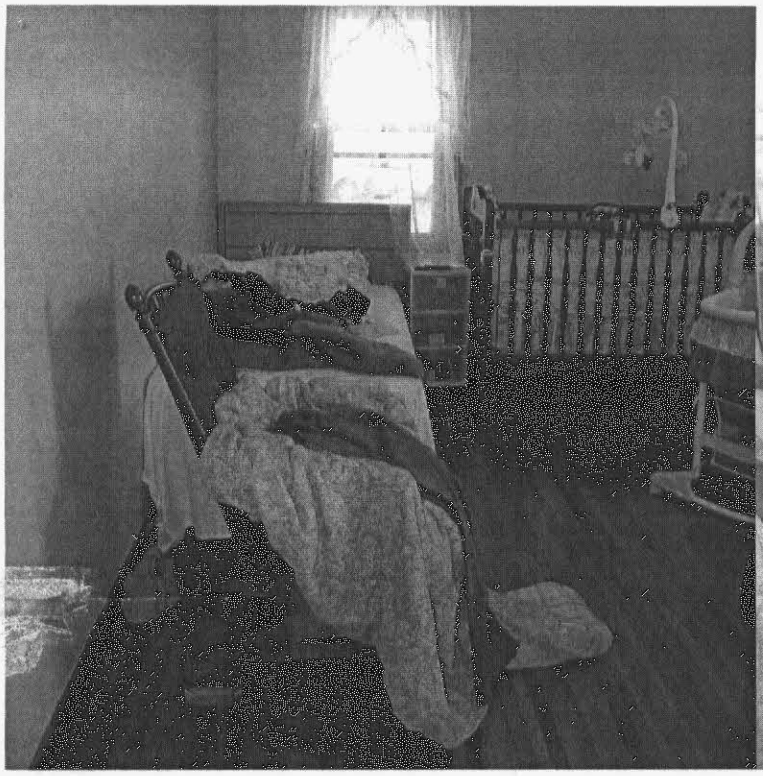
(13) Lab Exhibit Number(s)	(14) CSSC Exhibit Number(s)	(15) Agency Exhibit Number(s)	(16) (17) Evidence description (see instructions)
	1		SBBC (1) Bumper pad from crib
			(1) Large Winnie the Pooh blanket
			(1) Comforter from crib
			(1) Fitted sheet from crib
			(1) Diaper from bathroom floor
			(1) Bottle of oral medication
			(1) White & yellow one piece sleeper
			(1) Diaper removed from victim
			(1) Bib
			(1) Can of Similac formula

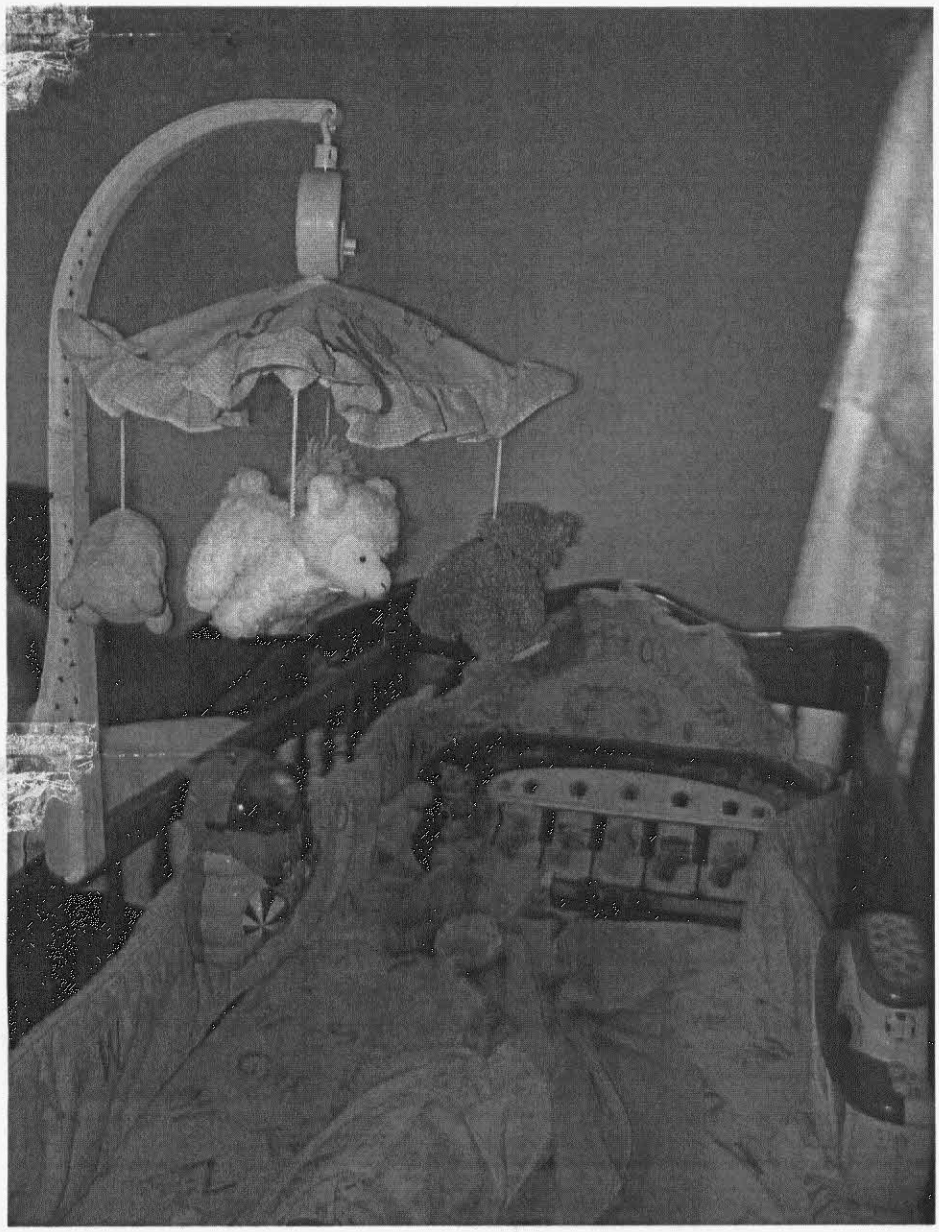
(18) Lab use only

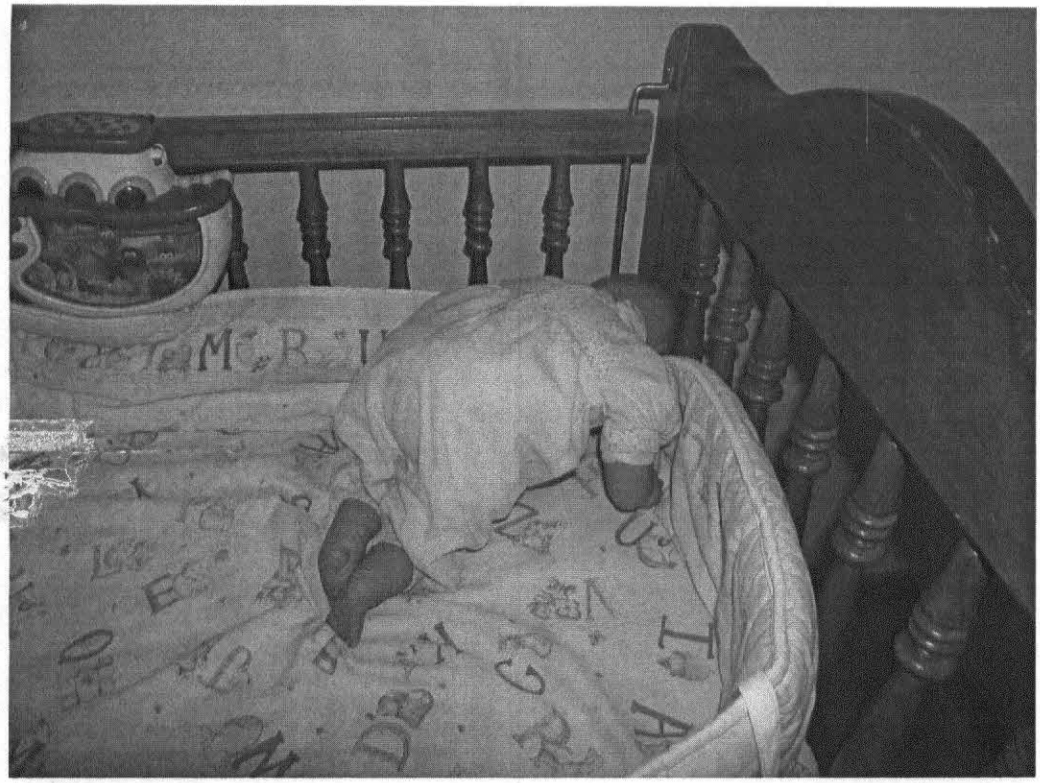
(25) Attach pertinent case information, the case summary, and examination requests
IMPORTANT: List any communicable diseases of risk to lab personnel (e.g., hepatitis, TB HTLV/LAV II, etc.

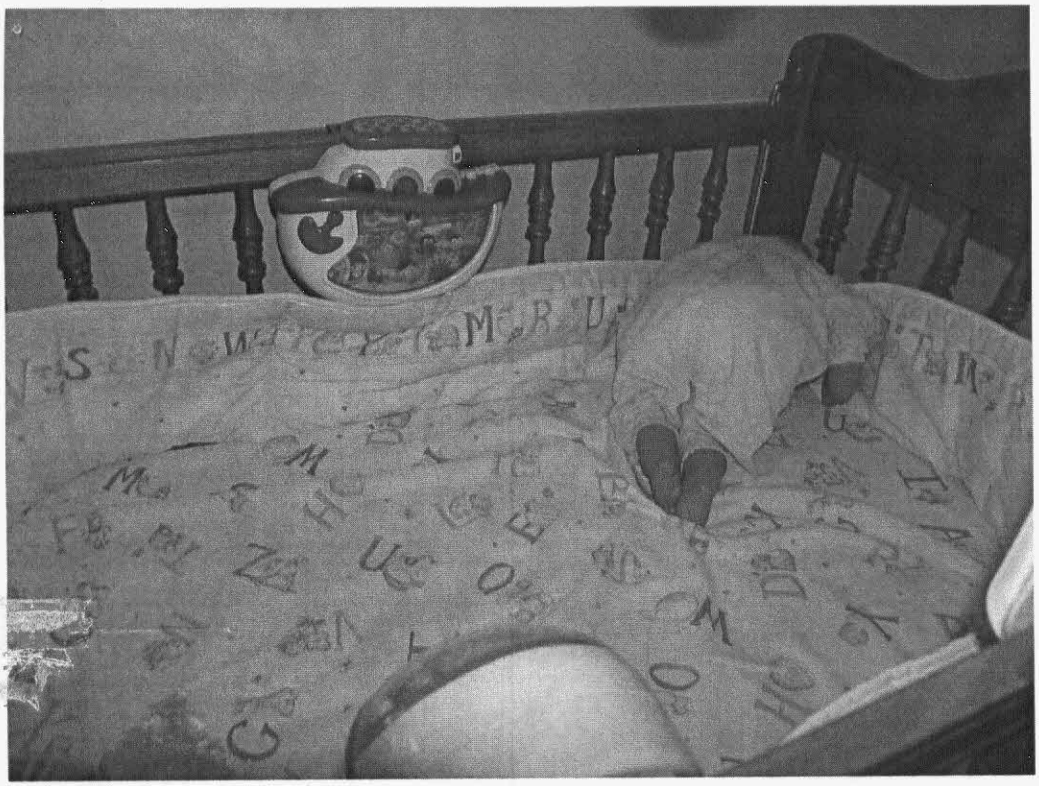
CHAIN OF EVIDENCE

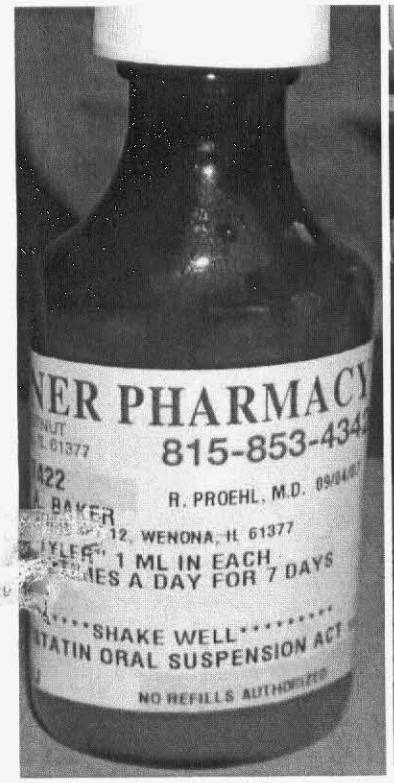
(26) Lab Exhibit Number(s)	(27) CSSC Exhibit Number(s)	(28) Date	(29) Returned By (DFS Employee Signature)	(30) Released to (law enforcement representative signature and agency name if applicable)
	1	9/8/07	Tpr. H. N. Hansen #4615	DUTKO #11







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R. PROEHL, M.D.
12, WENONA, IL 61377
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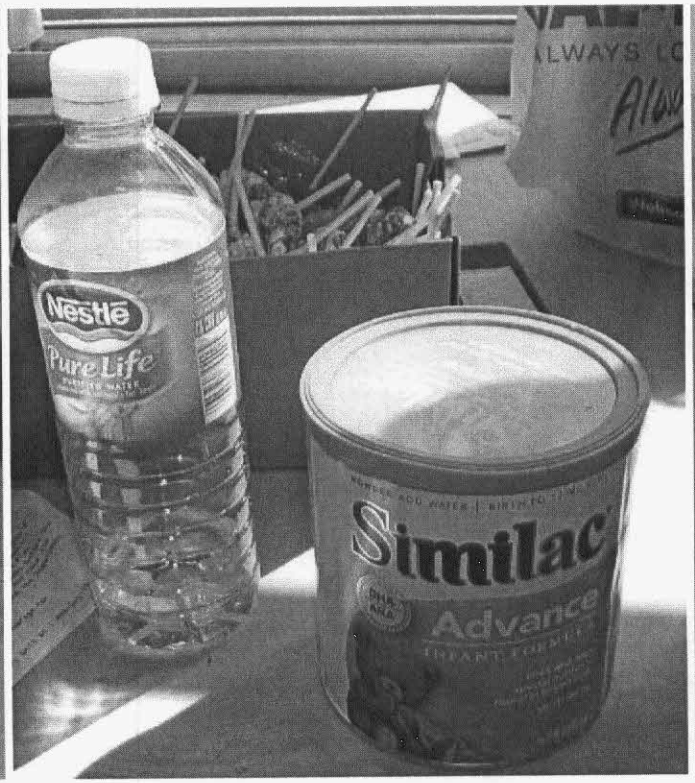
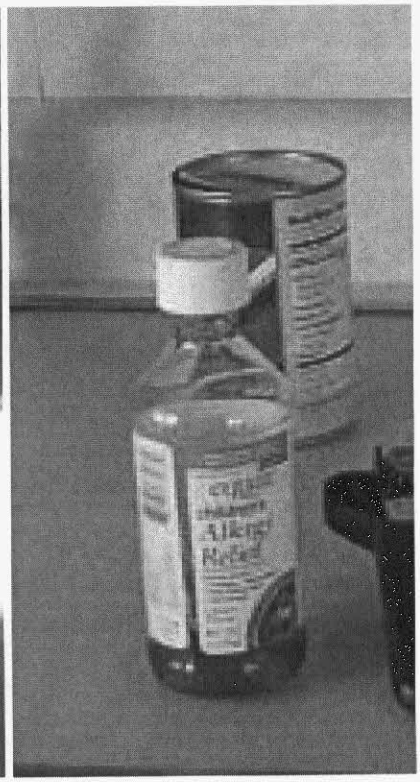
NO REFILLS AUTHORIZED


Nestlé
Pure Life
Similac
Advance



LIVINGSTON CO. SHERIFF POLICE
INCIDENT REPORT
844 W. LINCOLN ST.
PONTIAC IL 61764

921721-07
RUN TIME 15:18:10
RUN DATE- 9/11/07

COPY FOR: RECORDS/FILE
TELEPHONE:815-844-2774

INCIDENT # - 921721-07 FILE CLASS-00000/9439 STATUS-ADMIN. CLOSED
CITY/TOWN - T100-PIKE TOWNSHIP LOCATION - T100
OFFENSE - 9439 OTHER SUDDEN DEATH AND BODIES FOUND
MAIN BADGE: LIV - 005 ASST1: LIV - 011
OCCURRED - 9/07/07 07:14 ZONE-
REPORTED - 9/07/07 07:14 RESPONSIBLE-LIV -LIVINGSTON COUNTY SHERIFF
DISPATCHED- 9/07/07 07:14 RESPONDING -LIV -LIVINGSTON COUNTY SHERIFF
ARRIVED - 9/07/07 07:32
CLEARED - 9/07/07 10:36

COMPLAINANTS:

[redacted], IL SEX:F RACE:W DOB:11/28/83 RP 9439
HOME[redacted]
EYES:BLU HAIR:BLN HGT:5-09 WGT:140 SS# 000-00-0000 DL#:IL/[redacted]
CELL #: [redacted]

[redacted] IL SEX:M RACE:W DOB: 7/09/76 RP 9439
HOME#[redacted]
EYES:HAZ HAIR:BRO HGT:5-08 WGT:140 SS# [redacted] DL#:IL/[redacted]
CELL #: [redacted]
WORK: [redacted]

VICTIMS:

[redacted] SEX:M RACE:W DOB: 4/06/07 VI 9439
HOME#:

MISCELLANEOUS:

[redacted] WENONA, IL SEX:F RACE: DOB:12/09/86 MS 9439
HOME#:[redacted]

[redacted] SEX:M RACE:W DOB:11/30/81 MS 9439
HOME#:[redacted]
EYES:BRO HAIR: HGT:5-08 WGT:176 SS# 000-00-0000 DL#:IL/B26001281340

[redacted] IL SEX:F RACE:W DOB: 6/24/01 MS 9439
HOME#:

[redacted] IL SEX:M RACE:W DOB: 7/10/35 MS 9439
HOME#:[redacted]

[redacted] IL SEX:F RACE:W DOB:10/10/40 MS 9439
HOME#:[redacted]

[redacted] SEX:M RACE:W DOB: 5/18/84 MS 9439
HOME#:

REPORTING OFFICER _____ DATE ___/___/___
TYPIST - KJS SERGEANT MARIE MARGHERIO

REVIEWED BY _____ DATE ___/___/___

LIVINGSTON CO. SHERIFF POLICE
Incident Report
112 W. MADISON ST.
PONTIAC IL 61764

Phone:(815)844-2774

Report 07-0921721
Date 09/11/07
Time 3:14 PM

Narrative:

9/7/07 0714 report of 10-79 infant at [redacted], IL. Reported by babysitter Theresa McMillan and boyfriend Bryon Melvin 815 579-2448.

I arrived at approximately 0732 hrs 9/707. Flanagan EMS were on scene. Coroner Mike Burke had been notified. Coroner Burke requested on call Det. Earl Dutko. Det. Dutko requested ISP Crime Scene Techs (Heather Hanson and Intern Rossi).

Det. Dutko arrived at approximately 0753 hrs. At my arrival I entered this residence and was led by EMS to a bedroom with a baby crib a bed and other infant types of items.

I observed a caucasian infant approximately5 months of age lying on his back with arms bent at the elbows and arms reaching upward. The hands were partially closed and the infant's skin tone was cyanotic. The eyes and mouth were closed. The baby's body was in rigor mortis. The left leg was slightly pulled up the right leg was straight.

This infant [redacted] 4/6/07 was wearing white P.J.s with yellow chickens and a chicken emblem on the left chest and the wording "Just chicken".

I later learned the infant [redacted] had been laying on his stomach and had been picked up by the babysitter [redacted] and then placed the unresponsive child in the baby bed on his back.

[redacted] states the baby's mother is [redacted] and [redacted] lived in Wenona, IL. [redacted] could not give an address but did give a phone number. Those living in the 700 E [redacted] residence are [redacted] n, boyfriend of [redacted] and [redacted] n (age 6). [redacted] stated the baby was ok around 5 A.M. and that she checked on him around 0700 A.M. and [redacted] was unresponsive. [redacted] states she called 911.

[redacted] n states he came home from work around 1130 PM and checked on the baby. [redacted] states the baby was a little fussy and he turned on the mobile and [redacted] was fine. [redacted] states in the morning he heard [redacted] screaming and he ran to [redacted] room and saw the baby was blue and [redacted] calling 911. [redacted] stated the baby had not been ill.

Arrangements were made with Wenona Chief of Police Bill Butler to contact [redacted] for notification to be made.

LIVINGSTON CO. SHERIFF POLICE
Incident Report
112 W. MADISON ST.
PONTIAC IL 61764

Phone:(815)844-2774

Report 07-0921721
Date 09/11/07
Time 3:14 PM

Narrative:

Chief Butler called from [redacted]'s and put [redacted] on the phone. I introduced myself and advised [redacted] Mike burke needed to speak with her. I then handed the phone to coroner burke. This was at approximately 0849. Donald [redacted] and [redacted], grandparents of babysitter [redacted] came to be with the family.

[redacted] brother of [redacted] and [redacted] uncle drive [redacted] and [redacted] to 700 E [redacted] was removed by SELCAS ambulance. Donita was the attendant.

Livingston County Sheriff's Police
Incident Report Narrative

Case #: 0921721

9-7-07 0714 Report of 10-79 infant at [redacted] IL. Reported by babysitter [redacted] and boyfriend [redacted]

I arrived at approximately 0732hrs 9-7-07. Flanagan EMS were on scene. Coroner Mike Burke had been notified. Coroner Burke requested on call Det. Earl Dutko. Det. Dutko requested ISP Crime Scene Techs. (Heather Hanson and Intern Rossi)

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This infant [redacted] 4-6-07 was wearing white P.J with yellow chickens and a chicken emblem on the ~~right~~ LEFT chest and the wording "Just Chicken".

I later learned the infant [redacted] had been lying on his stomach and had been picked up by the

Reporting Officer Signature: Sgt Mangherid I.D.#: 5 Date: 9-07-07 Time:

babysitter [redacted] and then placed the unresponsive child in the baby bed on his back.
[redacted] states the babys mother is [redacted] [redacted] and [redacted] lived in Wenona IL. [redacted] could not give an address but did give a phone number.
Those living in the 7000 [redacted] address residence are [redacted] [redacted] (age 6). boyfriend of [redacted] and [redacted]
[redacted] stated the baby was ok around 5AM and that she checked on him around 0700 A.M and [redacted] was unresponsive. [redacted] states she called 911.
[redacted] states he came home from work around 1130PM and checked on the baby [redacted] states the baby was a little fussy and he turned on the mobile and [redacted] was fine.
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Arrangements were made with Wenona Chief of Police Bill Butler to contact [redacted] for notification to be made.
Chief Butler called from [redacted] and put [redacted] on the phone. I introduced myself and advised [redacted] Mike Burke needed to speak

Reporting Officer Signature: Sgt Ma[illegible] I.D.#: 5 Date: 9-7-07 Time:

Livingston County Sheriff's Police
Incident Report Narrative

Case #: 0921721

Page 3 of __

With her. I then handed the phone to Coroner Burke. This was at approximately 0849. [redacted] and [redacted], grandparents of babysitter Theresa McMillan came to be with the family.

[redacted], brother of [redacted] and [redacted] uncle drove [redacted] and [redacted] to 700E [redacted] IL.

[redacted] was removed by Selcis Ambulance. Donita was the attendant

Reporting Officer Signature: S. + M. [signature] I.D.#: 5 Date: 9-7-07 Time: ____

COPY FOR: RECORDS/FILE

TELEPHONE:815-844-2774

LIVINGSTON CO. SHERIFF POLICE
INCIDENT REPORT
844 W. LINCOLN ST.
PONTIAC IL 61764

921721-07 A
RUN TIME 13:26:18
RUN DATE- 9/11/07

INCIDENT # - **921721-07A** FILE CLASS-**00000/9439** STATUS-**ADMIN. CLOSED**
CITY/TOWN - **T100-PIKE TOWNSHIP** LOCATION - **T100**
OFFENSE - **9439 OTHER SUDDEN DEATH AND BODIES FOUND**
MAIN BADGE: **LIV - 011** ASST1: **LIV - 005**
OCCURRED - **9/07/07 07:14** ZONE-
REPORTED - **9/07/07 07:14** RESPONSIBLE-**LIV -LIVINGSTON COUNTY SHERIFF**
DISPATCHED- **9/07/07 07:40** RESPONDING -**LIV -LIVINGSTON COUNTY SHERIFF**
ARRIVED - **9/07/07 07:53**

COMPLAINANTS:

[redacted] IL 61740 SEX:F RACE: DOB:**11/28/83** RP 9439
HOME#[redacted]
EYES:**BLU** HAIR: HGT:**5-06** WGT:**145** SS# **000-00-0000** DL#:IL/[redacted]

VICTIMS:

[redacted] IL SEX:M RACE:W DOB: **4/06/07** VI 9439
HOME#:

MISCELLANEOUS:

[redacted] IL SEX:F RACE:W DOB:**12/09/86** MS 9439
HOME#[redacted]

[redacted] SEX:M RACE: DOB:**11/30/81** MS 9439
HOME#[redacted]
EYES:**BRO** HAIR: HGT:**5-08** WGT:**176** SS# **000-00-0000** DL#:IL/[redacted]

PROPERTY:

[redacted] PR 9439
CODE E TYPE **CLOT** CLASS **3** QUANTITY DISPOSITION CODE
DESCRIPTION: **BABY ITEMS RECOVERED FROM RESIDENCE**
STORAGE LOCATION ROOM: **MEB** SHELF: BIN: **O-1**

LCSP, PR 9439
CODE E TYPE **MISC** CLASS **11** QUANTITY DISPOSITION CODE
DESCRIPTION: **AUDIO CASSETTE OF PHONE CALL**
NIC #: TAG #: **CASE FILE**

REPORTING OFFICER [signature] DATE 9/11/07
TYPIST - **ELD** **DETECTIVE EARL L. DUTKO**

REVIEWED BY _____ DATE ___/___/___

LIVINGSTON CO. SHERIFF POLICE
Incident Report
112 W. MADISON ST.
PONTIAC IL 61764

Phone:(815)844-2774

Report 07-0921721
Date 09/11/07
Time 1:23 PM

Narrative:

On 9/7/07 R/O was called to the scene of an infant death at [redacted] Sgt. Margherio was on scene, the coroner had been contacted and I requested ISP Crime Scene Tech. Upon my arrival Coroner Burke was on scene along with Flanagan EMS. Present for Flanagan were [redacted] was the only EMS personnel that went into the baby's room. She stated that the baby was lying on his back, he was cold to the touch. She said he was obviously deceased and she did not move him.

I next spoke with [redacted], the babysitter of the victim [redacted] stated [redacted] was her cousin [redacted]'s son. She watches him every other Thursday for [redacted]. He was brought over around 1430 yesterday. His mother left a medical card for him in case she had any problems because he had been pulling at his ears. She said that he was normal last night. She gave him a bottle this morning at 0500hrs and changed his diaper, which was dry. She said she gave him the bottle in the living room in the recliner. He took around 4oz of Similak and she put him back down. I asked how he was sleeping. She said that he always sleeps on his stomach, this is the only way that he sleeps. She said he had the bumper pad pulled down like he was snuggling with it. [redacted] said she was sleeping on the couch because there was no baby monitor. At 0710hrs her daughter [redacted] woke her up. She went in and checked on [redacted] and he looked like he wasn't breathing. She turned him over and he was purple, so she called 911.

I spoke with [redacted] who also lives in the house. He stated that he got home from work at 2300hrs and checked on [redacted] It was getting cool outside, so he shut the windows in the room. [redacted] heard him and fussed a little so he turned the radio on for him. I asked him about any pets in the house. He said they do not have any pets that stay in the house.

In an attempt to locate an address for [redacted] got into the diaper bag. She pulled out a bottle of

LIVINGSTON CO. SHERIFF POLICE
Incident Report
112 W. MADISON ST.
PONTIAC IL 61764

Phone:(815)844-2774

Report 07-0921721
Date 09/11/07
Time 1:23 PM

Narrative:

medication with her address on it. I asked her about the medication(Nystatin). She said that she did not know it was in there and [redacted] didn't say anything to her about giving it to him. The bottle was dated 9/4/07 with [redacted] as the Physician.

When [redacted]s mother and father arrived I spoke with them. She is twenty years old and [redacted] is her first and only child. Theresa keeps him for her every other Thursday so she can get a good night's sleep. He currently has an ear infection that he has not been to the Dr. for yet. He went to the Dr. most recently for Thrush, which is what the medication was for. She said he has white on his tongue and the sides of his throat. She said that [redacted] knew about the Thrush. This was the only medication he was on and he has had no other problems. I asked her about his sleeping habits. She said he gets six ounces of Similac every four to six hours. She said he gets up every night around 0200hrs and again at 0600hrs for a bottle. He also gets baby food in the morning and at bedtime. I asked [redacted] about the formula. He said that he bought it at the Eureka IGA yesterday. As far as their home, it is just [redacted] and Aaron.

ISP CST Hanson arrived and photographed the scene and recovered some items. Hanson also had [redacted]a come into the room and with a doll demonstrate how the baby was laying when she found him. [redacted] took the doll and pushed him up into the N/W corner of the crib, pulled the bumper pad down under his head, and tucked his feet under his body.

The body was removed from the scene by Selcas personnel.

On 9/8/07 R/O observed the autopsy at the McLean County Morgue. It was performed by Dr. Denton. His preliminary finding was that there was no sign of Trauma, infection or abuse. His official findings will be pending further tests. Given the situation of how the baby was found, Dr. Denton was discussing the possibility of asphyxia.

SAINT JAMES HOSPITAL
PONTIAC, ILLINOIS

NEWBORN INITIAL PROFILE

BASIC DATA

Infant's ID. No. 02628 Infant's Record No. 584555

☒ Male ☒ Vaginal
☐ Female ☐ C-Section EDC 4-14-07 (MO/DAY/YR) Delivery Date 4-6-07 (MO/DAY/YR)

Time of Birth 1955 AM (PM) Apgar At: 7 1 min. 9 5 min.

Place of birth: ☒ Hospital ☐ En Route ☐ At Home ☐ _____

Mother's Name: [redacted] Age: 20

Mother's Record No.	Blood Type and Rh	G	T	Pt	A	L
570053	A+	2	1	—	1	1

BIRTHWEIGHT / GESTATIONAL AGE ASSESSMENT

Weight 5 lbs. 11 oz. (gms.)
Length 17½ in. (cm.)
Head Circ. 33 in. (cm.)
Gest. Age by Dates 38 wks.
Gest. Age by Exam 39 wks.

This infant is classified as:
☐ Pre-term (less than 38 Wks.)
☒ Term (38-42 Weeks)
☐ Post-term (greater than 42 weeks)

☐ SGA ☒ AGA ☐ LGA

NEWBORN DISCHARGE SUMMARY

Infant's Name [redacted] A.

Ethnicity/ Race of: Mother Father
Caucasian ..... ☒ ☒
Black ..... ☐ ☐
Other _____ _____

Discharge Weight 5 lbs. 9 oz. (gms.)

Newborn Discharged on 4/8/07 (MO/DAY/YR)

Time 1245 AM PM

☒ To Home
☐ Other _____

Date	Tests	Results or ☐ If done
4/6	Blood Type	☐ B+
4/6	Coombs Dir. Indir.	☐ Neg
4/	Serology	☐
4/8	PKU Blood Urine	☑
4/8	Thyroid T4 TSH	☑
/	Bili ✓	☐ 9.4 @ 37½
/		☐ Total
/	Serum	☐ 7.8
/		☐ Dir 0.2

Hearing Screen passed

Follow-up Visit Scheduled for Call Dr. [redacted] office Mon or Tues (MO/DAY/YR)

With [redacted]

Signature: Triplett

PHYSICAL EXAMINATION

Date 4/7 (MO/DAY/YR) Time 10:20 AM (PM) Baby's Age 13 Hrs.

SYSTEM	Normal	Abnormal	Check and detail all Positive Findings
Tone/Appearance	☑	☐	
Skin: Color, Lesions	☑	☐	
Head/Neck	☑	☐	
Eyes	☑	☐	
ENT	☑	☐	
Thorax	☑	☐	
Lungs	☑	☐	
Heart	☑	☐	
Abdomen	☑	☐	
Umbilicus	☑	☐	
Femoral Pulses	☑	☐	
Genitals	☑	☐	
Anus	☑	☐	
Trunk/Spine	☑	☐	
Extremities/Joints	☑	☐	
Neurologic/Reflexes	☑	☐	

Physician's Signature: [signature]

Date 4/8/07 (MO/DAY/YR) Time 8:00 AM PM Baby's Age 38 Hrs.

SYSTEM	Normal	Abnormal	Check and detail all Positive Findings
Tone/Appearance	☑	☐	
Skin: Color, Lesions	☑	☐	
Head/Neck	☑	☐	
Eyes	☑	☐	
ENT	☑	☐	
Thorax	☑	☐	
Lungs	☑	☐	
Heart	☑	☐	
Abdomen	☑	☐	
Umbilicus	☑	☐	
Femoral Pulses	☑	☐	
Genitals	☑	☐	
Anus	☑	☐	
Trunk/Spine	☑	☐	
Extremities/Joints	☑	☐	
Neurologic/Reflexes	☑	☐	

Physician's Signature: [signature]

Feeding: ☐ Breast ☒ Formula
(Special): Similac

Medications: ☒ None
(or): _____

Instructions: ☒ Routine
(or): _____

Name: [redacted] Boy
DOB: 04/06/2007 Age: 1D Sex: M
MRN: 00584555 Account #: [redacted]
Room/Bed NURY-01 Admit Date: 04/06/2007 7:55pm
Attn Prov: [redacted]

NEWBORN MATURITY RATING & CLASSIFICATION

ESTIMATION OF GESTATIONAL AGE BY MATURITY RATING
Symbols: X - 1st Exam O - 2nd Exam

Side 1

Gestation by Dates 38 wks

Birth Date 4-6-07 Hour 1955 am pm

APGAR 7 1 min 9 5 min

NEUROMUSCULAR MATURITY

	-1	0	1	2	3	4	5
Posture							
Square Window (wrist)	>90°	90°	60°	45°	30°	0°	
Arm Recoil		180°	140°-180°	110°-140°	90-110°	<90°	
Popliteal Angle	180°	160°	140°	120°	100°	90°	<90°
Scarf Sign							
Heel to Ear							

PHYSICAL MATURITY

Skin	sticky friable transparent	gelatinous red, translucent	smooth pink, visible veins	superficial peeling &/or rash, few veins	cracking pale areas rare veins	parchment deep cracking no vessels	leathery cracked wrinkled
Lanugo	none	sparse	abundant	thinning	bald areas	mostly bald	
Plantar Surface	heel-toe 40-50mm:-1 <40mm:-2	>50mm no crease	faint red marks	anterior transverse crease only	creases ant. 2/3	creases over entire sole	
Breast	imperceptible	barely perceptible	flat areola no bud	stippled areola 1-2mm bud	raised areola 3-4mm bud	full areola 5-10mm bud	
Eye/Ear	lids fused loosely:-1 tightly:-2	lids open pinna flat stays folded	sl. curved pinna; soft; slow recoil	well-curved pinna; soft but ready recoil	formed & firm instant recoil	thick cartilage ear stiff	
Genitals male	scrotum flat, smooth	scrotum empty faint rugae	testes in upper canal rare rugae	testes descending few rugae	testes down good rugae	testes pendulous deep rugae	
Genitals female	clitoris prominent labia flat	prominent clitoris small labia minora	prominent clitoris enlarging minora	majora & minora equally prominent	majora large minora small	majora cover clitoris & minora	

Scoring system: Ballard JL, Khoury JC, Wedig K, Wang L, Eilers-Walsman BL, Lipp R. New Ballard Score, expanded to include extremely premature infants. *J Pediatr.* 1991;119:417-423.

MATURITY RATING

score	weeks
-10	20
-5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

SCORING SECTION

	1st Exam=X	2nd Exam=O
Estimating Gest Age by Maturity Rating	39 Weeks	____ Weeks
Time of Exam	Date 4-6 Hour 2025 am pm	Date ____ Hour ____ am pm
Age at Exam	NB Hours	____ Hours
Signature of Examiner	BKuttner M.D.	____ M.D.

19

Name: [redacted]
DOB: 04/06/2007 Age: 1D Sex: M
MRN: 00584555 Account #: 003968364
Room/Bed NURY-01 [redacted]/2007 7:55pm
Attn Prov: [redacted]

Maker of:
Mead Johnson NUTRITIONALS
Enfamil® Infant Formula for 0-12 Months
Enfamil® with Iron Infant Formula for 0-12 Months
ProSobee® Soy Formula for 0-12 Months
Nutramigen® Hypoallergenic Protein Hydrolysate Formula with Iron

8146-10-92

OSF
SAINT JAMES - JOHN W. ALBRECHT MEDICAL CENTER
2500 W. Reynolds Street
Pontiac, Illinois 61764

NEWBORN DISCHARGE INSTRUCTION SHEET

Birth Weight 5lb. 11oz. PKU Done X Yes ____ No

Today's Weight 5 lbs 9oz Hepatitis B Vaccine Given ✓ Yes ____ No at birth

Baby's Blood Type B+ Bathed infant X Yes ____ No

See Dr. [redacted] in ____ ~~weeks~~. call office Monday, April 9th.

CORD CARE

[X] Apply alcohol to the base of the cord twice a day.

[ ] ~~May use peroxide 3-4 times per day as needed.~~

[ ] ~~Cord has been triple dyed.~~

CIRCUMCISION CARE

[ ] ~~Plastibell - will fall off in 7-10 days. Clean with soap and water. Gently lift plastic ring up at diaper changes.~~

[X] Other - Clean with soap and water 2-3 times per day. Apply a small amount of vaseline to circumcision edge for 1-2 days, only if needed. Keep any remaining foreskin pushed back. Starting tomorrow

[ ] ~~Uncircumcised - Clean with soap and water. Do not attempt to push foreskin back.~~

BREASTFEEDING

1. Feed on demand (every 2-4 hours)
2. Use bottled water until baby is one year old
3. If baby has fewer than six wet diapers and 4 stools in 24 hours, baby may be getting dehydrated, encourage frequent feedings

Similac Advance

BOTTLE FEEDING

1. Burp baby every 1/2 ounce
2. Feed on demand (2-6 hours)
3. Do not use tap water until infant is a year old

SPECIAL INSTRUCTIONS

Call Physician If - Baby has a rectal temperature over 100.4 degrees F, any breathing problems, any bloody or light green, foamy stools, any yellow-green drainage from his/her eyes, cord, or circumcision.

Hearing Test - passed

MEDICATIONS

none

JAUNDICE

- Notify Physician If: see handout, also

Bili Check at 38½ hours = 9.4
(+) Serum bili - total 7.8, direct 0.2.

1. Infant's skin becomes yellow beyond the upper chest when looking at the infant in sunlight.
2. Infant becomes very sleepy and sleeps through one feeding and still does not arouse.
3. If baby has fewer than 6 wet diapers and 4 stools in 24 hours, baby may be getting dehydrated, encourage frequent feedings.

Repeat bilirubin to be done ____ in hospital Laboratory.

1. Notify your physician if problems or concerns arise regarding infant.
2. Obstetrical Department Phone (815) 842-~~BABY~~ 4972

Newborn ID# 2628
Identical to mother [redacted]
& infant bracelets [redacted] (mothers initials)

I have read and understand the above printed and verbal instructions.

[redacted]
PARENT OR SIGNIFICANT OTHER SIGNATURE

[redacted] 4/7/07
NURSE'S SIGNATURE DATE

AGE

Name: [redacted]
DOB: 04/06/2007 Age: 1D Sex: M
MRN: 00584555 Account #: [redacted]
Room/Bed NURY-01 Admit Date: 04/06/2007 7:55pm
Attn Prov: [redacted]

OSF MEDICAL GROUP

~~TWO~~ one MONTH EXAM

Name: [redacted] Exam Date: 5/23/07

D.O.B.: 4-6-07 Age: 6 weeks Informant / Reliability: mom

HISTORY / REVIEW OF SYSTEMS:

Feeding type: Similac Advance Amount: 3oz Frequency: 93
Vitamins / fluoride: Iron
GI / Stools: encouraged to use Nursing water
Sleep: Up twice at nr Constipation GU/Circ: was circumcised
Skin / Diaper Rash: Ø Cord: cord off
Allergies: NKA
Medications: Ø except Infant gas drops

☐ All other systems reviewed (see reverse) and are negative
☐ All systems negative, except:

Wt 25% Ht 5%
HC 25%

PAST HISTORY / BIRTH HISTORY:

☐ Reviewed (see reverse); no changes since ___/___/___
☐ No changes since documentation of ___/___/___ except:

SOCIAL HISTORY:

☐ Reviewed (see reverse); no changes since ___/___/___
☐ No changes since documentation of ___/___/___ except:

FAMILY HISTORY:

☐ Reviewed (see reverse); no changes since ___/___/___
☐ No changes since documentation of ___/___/___ except:

DEVELOPMENT:

☑ Lifts head in prone position
☐ Focuses and tracks briefly
☑ Attends to noise; smiles

ANTICIPATORY GUIDANCE (Circle if H/O given):

☑ Car/infant seat; falls; pets
☑ Crying/sleep patterns; sleeping position; colic
☑ Fever; antipyretics; gastroenteritis
☑ Formula/breast only; water (< 4 oz. per day)

IMMUNIZATIONS DUE: Ø

PREVIOUS SHOT REACTIONS:

PROBLEMS:

with bowel movements

Pain Assessment: 0 1 2 3 4 5 6 (7-8) 9 10
Nutritional Risk: ☐ No ☐ Yes - See Form

History / VS taken by (signature): [signature]
Pre-printed items are completed as medically indicated

PHYSICAL EXAMINATION:

Ht: 20½" Wt: 9#5oz HC: 15" Birth Wt: 5#11oz
{T: 99.6 (R) P: 180 R: 40 BP: / }

ORGAN SYSTEM (describe abnormals below)	Normal	Abnl
GEN/CONST: body habitus, nutrition, grooming	☑	☐
SKIN: inspect/palpate, rash, nevi, hemangioma, cafe au lait	☑	☐
HEAD: shape, symmetry, AF, PF, sutures	☑	☐
EYES: conjunctiva, lids, pupils, irises, red reflex	☑	☐
EARS/NOSE: ext. ear, canals, pneumatic otoscopy, TM's, nares, nasal mucosa, septum	☑	☐
MOUTH: lips, gums, palate, buccal mucosa, pharynx	☑	☐
NECK: symmetry, masses, tracheal position, torticollis thyroid	☑	☐
CHEST: breast hypertrophy, symmetry, palpation	☑	☐
LUNGS: resp. effort, ~~percussion~~, auscultation	☑	☐
CV: palpation-PMI, S1, S2, extra sounds, murmurs, femoral pulses, brachial pulses, bruits	☑	☐
GI/ABD: palpation, auscultation, masses, liver, spleen, hernias, umbilicus, anus	☑	☐
GU: bladder, hernia, penis, scrotum, circumcision, ext. female genitalia	☑	☐
LYMPH NODES: neck, axillae, groin, other	☑	☐
MUSCULOSKEL: hip abduction/dislocation, creases, digits/nails, symmetry, masses, deformity	☑	☐
NEURO: Moro, grasp, tone, DTR's, cranial nerves/facial symmetry	☑	☐

ABNORMAL FINDINGS:

PROBLEMS / PLANS / INSTRUCTIONS:

① 6 wk PE - health, antic guidance given
f/u 2 3 wk for 2 m WCC.

Newborn screen: _____ Labs: _____
Immunizations given: ☐ NO ☐ YES - see Imm. Flowsheet
INFORMED CONSENT DISCUSSED: ☐ YES ☐ N/A
Patient Education: ☐ NO ☐ YES _____ ☐ H/O given
Medication instructions given: ☐ YES ☐ N/A
RTC:
Signature: [signature]

Name: [redacted] Exam Date: _____ DOB: 4-6-07

DEVELOPMENT / ANTICIPATORY GUIDANCE PROMPTS:

SAFETY:
Car seat: must ride in backward-facing approved car seat.
Falls: infant may be able to scoot/roll. Never leave unattended.
Pets: do not leave infant alone/unattended with pet.

ILLNESS:
Fever: Temp ≥ 101° may be significant; parent should call office. Tell parent approp. acetaminophen dose.
Gastroenteritis: clear liquids (Pedialyte) for 12 - 24 hrs, then advance diet as tolerated. Call if elevated temp, bloody stools, or signs/sx of dehydration. Breastfed infants may continue to nurse if tolerating it well.

BEHAVIOR:
Crying: determine if excessive. Discuss parent's management of crying - are they able to "take a break?"
Sleep patterns: may sleep 5-8 hours at a time; should be in own bed.
Sleeping position: on back/side to reduce SIDS risk.

FEEDINGS:
Water: infant may have plain water, but not > 4 oz. day.
Formula: 4 - 6 oz., every 3 - 4 hours. Don't prop bottles.
Breast: feed on a "demand" schedule every 1½ - 4 hours.
Solids: no need for solids until at least age 4 - 6 months.

REVIEW OF SYSTEMS
(mark box if reviewed; circle abnormals)

- ❑ **REVIEWED ALL**
- ❑ **CONSTITUTIONAL:** development, fever, fatigue, appetite, weight Δ
- ❑ **INTEGUMENT:** rashes, lumps, birthmarks, lesions, itch, nails, breasts
- ❑ **EYES:** vision, strabismus, infection, redness, pain, glasses/contacts
- ❑ **EARS/NOSE/MOUTH/THROAT:** hearing, infections, pain, drainage, bleeding, obstruction, snoring, smell, dentition, palate, tongue, ulcers
- ❑ **RESP:** wheeze, cough, apnea, choking, SOB, pain, hemoptysis
- ❑ **CV:** BP, murmur, rheumatic fever, exercise tolerance, tachycardia, irreg. heart rate, chest pain, edema
- ❑ **GI:** abd. pain, bleeding, ulcers, jaundice, reflux, anorexia, nausea, vomiting, constipation, diarrhea, IBS, bloating, heartburn
- ❑ **GU:** infection, nocturia, urgency, frequency, blood in urine, incontinence, dysmenorrhea, spotting, ureteral reflux
- ❑ **MUSCULOSKELETAL:** deformities, gait, joint swelling, arthritis, extremity pain, dislocations, fractures, neck injury, back problems
- ❑ **ENDOCRINE:** growth, polyuria, polydipsia, menstrual problems, thyroid problems, blood sugar
- ❑ **NEURO:** seizures, HA's, speech, educational achievement, coordination, balance, tremor, weakness
- ❑ **HEME/LYMPH:** anemia, lymph nodes, bleeding, bruising
- ❑ **ALLERGIC/IMMUNO:** allergic rhinitis/conjunctivitis, freq. infections
- ❑ **PSYCH:** stress, anxiety, nerves, depression, sleep, work, family

ABN: Hx of Constipation x 2 days
stools soft, but strains

FAMILY HISTORY

Stroke/heart disease
Sickle Cell:
Hip Problems:
Scoliosis:
Lazy Eye:
Kidney Disease:
Deafness:
SIDS/Early Infancy Deaths:
Allergies/Asthma/Eczema:
Cyctic Fibrosis:
Diabetes:
HTN:
Melanoma:
TB:
Anemia/Bleeding:
Seizures:

Mom-

511

PAST MEDICAL HISTORY

Birth Hx.: Term - Vaginal
Hospitalizations:
Fractures/Sutures:
Childhood illnesses:
Surgeries: (esp. removal of a paired organ)

SOCIAL HISTORY:

Parents: Mom + Dad. Siblings: ∅
Living arrangements:
Child Care arrangements:
Smokers in home:
Cultural practices/beliefs which may affect healthcare:
Other:

Mom is ill x lwk c̄ vrs

OSF® MEDICAL GROUP

TWO MONTH EXAM

Name: [redacted]

Exam Date: 6-8-07

D.O.B.: 4-6-07 Age: 2mo

Informant / Reliability: Mom - [redacted]

HISTORY / REVIEW OF SYSTEMS:

Feeding type: Similar Amount: 4oz Frequency: Q4°
Vitamins / fluoride: Advanced
GI / Stools: Regular
Sleep: 5hr.
Skin / Diaper Rash: scalp rash? GU/Circ: Cord: off + healed
Allergies: Ø
Medications: Ø

❑ All other systems reviewed (see reverse) and are negative
❑ All systems negative, except:

Ht 20%
Wt 20%

PAST HISTORY / BIRTH HISTORY:

❑ Reviewed (see reverse); no changes since 5/ /07
❑ No changes since documentation of ___/___/___ except:

SOCIAL HISTORY:

❑ Reviewed (see reverse); no changes since 5/ /07
❑ No changes since documentation of ___/___/___ except:

FAMILY HISTORY:

❑ Reviewed (see reverse); no changes since 5/ /07
❑ No changes since documentation of ___/___/___ except:

DEVELOPMENT:

☒ Lifts head in prone position
☒ Focuses and tracks briefly
☒ Attends to noise; smiles

ANTICIPATORY GUIDANCE (Circle if H/O given):

☒ Car/infant seat; falls; pets
☒ Crying/sleep patterns; sleeping position; colic
☒ Fever; antipyretics; gastroenteritis
☒ Formula/breast only; water (< 4 oz. per day)

IMMUNIZATIONS DUE: VFC Pediarix, Prevnar

PREVIOUS SHOT REACTIONS: HIB, RotaTeQ

PROBLEMS:

Pain Assessment: 0 1 2 3 4 5 6 7 8 9 10
Nutritional Risk: ☒ No ❑ Yes - See Form

History / VS taken by (signature): R Bills LPN
Pre-printed items are completed as medically indicated.

PHYSICAL EXAMINATION:

Ht: 22" Wt: 10-0½ HC: 15 Birth Wt: 5-11
{T: 97.8 P: 156 R: 60 BP: — }

ORGAN SYSTEM (describe abnormals below)	Normal	Abnl
GEN/CONST: body habitus, nutrition, grooming	☒	❑
SKIN: inspect/palpate, rash, nevi, hemangioma, cafe au lait	☒	❑
HEAD: shape, symmetry, AF, PF, sutures	☒	❑
EYES: conjunctiva, lids, pupils, irises, red reflex	☒	❑
EARS/NOSE: ext. ear, canals, pneumatic otoscopy, TM's, nares, nasal mucosa, septum	☒	❑
MOUTH: lips, gums, palate, buccal mucosa, pharynx	☒	❑
NECK: symmetry, masses, tracheal position, torticollis thyroid	☒	❑
CHEST: breast hypertrophy, symmetry, palpation	☒	❑
LUNGS: resp. effort, percussion, auscultation	☒	❑
CV: palpation-PMI, S1, S2, extra sounds, murmurs, femoral pulses, brachial pulses, bruits	☒	❑
GI/ABD: palpation, auscultation, masses, liver, spleen, hernias, umbilicus, anus	☒	❑
GU: bladder, hernia, penis, scrotum, circumcision, ext. female genitalia	☒	❑
LYMPH NODES: neck, axillae, groin, other	☒	❑
MUSCULOSKEL: hip abduction/dislocation, creases, digits/nails, symmetry, masses, deformity	☒	❑
NEURO: Moro, grasp, tone, DTR's, cranial nerves/facial symmetry	☒	❑

ABNORMAL FINDINGS:

PROBLEMS / PLANS / INSTRUCTIONS:

① 2 m WCC
anti sudden sica
f/u 4 m WCC

Newborn screen: _____ Labs: _____
Immunizations given: ❑ NO ☒ YES - see Imm. Flowsheet
INFORMED CONSENT DISCUSSED: ❑ YES ❑ N/A
Patient Education: ❑ NO ❑ YES _____ ❑ H/O given
Medication instructions given: ❑ YES ❑ N/A
RTC:
Signature: [signature]

[redacted] Exam Date: 6-8-01 DOB: 6-8-error LE

DEVELOPMENT / ANTICIPATORY GUIDANCE PROMPTS:

SAFETY:

Car seat: must ride in backward-facing approved car seat.
Falls: infant may be able to scoot/roll. Never leave unattended.
Pets: do not leave infant alone/unattended with pet.

ILLNESS:

Fever: Temp ≥ 101° may be significant; parent should call office. Tell parent approp. acetaminophen dose.
Gastroenteritis: clear liquids (Pedialyte) for 12 - 24 hrs, then advance diet as tolerated. Call if elevated temp, bloody stools, or signs/sx of dehydration. Breastfed infants may continue to nurse if tolerating it well.

BEHAVIOR:

Crying: determine if excessive. Discuss parent's management of crying - are they able to "take a break?"
Sleep patterns: may sleep 5-8 hours at a time; should be in own bed.
Sleeping position: on back/side to reduce SIDS risk.

FEEDINGS:

Water: infant may have plain water, but not > 4 oz. day.
Formula: 4 - 6 oz., every 3 - 4 hours. Don't prop bottles.
Breast: feed on a "demand" schedule every 1½ - 4 hours.
Solids: no need for solids until at least age 4 - 6 months.

REVIEW OF SYSTEMS

(mark box if reviewed; circle abnormals)

- ☐ **REVIEWED ALL**
- ☐ **CONSTITUTIONAL:** development, fever, fatigue, appetite, weight Δ
- ☐ **INTEGUMENT:** rashes, lumps, birthmarks, lesions, itch, nails, breasts
- ☐ **EYES:** vision, strabismus, infection, redness, pain, glasses/contacts
- ☐ **EARS/NOSE/MOUTH/THROAT:** hearing, infections, pain, drainage, bleeding, obstruction, snoring, smell, dentition, palate, tongue, ulcers
- ☐ **RESP:** wheeze, cough, apnea, choking, SOB, pain, hemoptysis
- ☐ **CV:** BP, murmur, rheumatic fever, exercise tolerance, tachycardia, irreg. heart rate, chest pain, edema
- ☐ **GI:** abd. pain, bleeding, ulcers, jaundice, reflux, anorexia, nausea, vomiting, constipation, diarrhea, IBS, bloating, heartburn
- ☐ **GU:** infection, nocturia, urgency, frequency, blood in urine, incontinence, dysmenorrhea, spotting, ureteral reflux
- ☐ **MUSCULOSKELETAL:** deformities, gait, joint swelling, arthritis, extremity pain, dislocations, fractures, neck injury, back problems
- ☐ **ENDOCRINE:** growth, polyuria, polydipsia, menstrual problems, thyroid problems, blood sugar
- ☐ **NEURO:** seizures, HA's, speech, educational achievement, coordination, balance, tremor, weakness
- ☐ **HEME/LYMPH:** anemia, lymph nodes, bleeding, bruising
- ☐ **ALLERGIC/IMMUNO:** allergic rhinitis/conjunctivitis, freq. infections
- ☐ **PSYCH:** stress, anxiety, nerves, depression, sleep, work, family

ABN:

FAMILY HISTORY

Stroke/heart disease
Sickle Cell:
Hip Problems:
Scoliosis:
Lazy Eye:
Kidney Disease:
Deafness:
SIDS/Early Infancy Deaths:
Allergies/Asthma/Eczema:
Cyctic Fibrosis:
Diabetes:
HTN:
Melanoma:
TB:
Anemia/Bleeding:
Seizures:

PAST MEDICAL HISTORY

Birth Hx.:
Hospitalizations:
Fractures/Sutures:
Childhood illnesses:
Surgeries: (esp. removal of a paired organ)

SOCIAL HISTORY:

Parents:
Siblings:
Living arrangements:
Child Care arrangements:
Smokers in home:
Cultural practices/beliefs which may affect healthcare:
Other:

OSF MEDICAL GROUP

FOUR MONTH EXAM

Name: [redacted]

Exam Date: 8-9-07

D.O.B.: 4-6-07 Age: _____ Informant / Reliability: Michelle

HISTORY / REVIEW OF SYSTEMS:

Feeding type: Similac Advance w/ Fe Amount: 6oz Frequency: 3-4°
Solids: Cereal stopped veg
Vitamins / fluoride:
GI / Stools: daily
Skin / Diaper Rash: spot on head
Allergies: Ø
Medications: Ø
Sleep: gets up 5x night
GU: Wets 3° Well

☐ All other systems reviewed (see reverse) and are negative
☐ All systems negative, except:

PAST HISTORY / BIRTH HISTORY:

☑ Reviewed (see reverse); no changes since 4 / 07
☐ No changes since documentation of ___/___/___ except:

SOCIAL HISTORY:

☑ Reviewed (see reverse); no changes since 4 / 07
☐ No changes since documentation of ___/___/___ except:
5 to nn

FAMILY HISTORY:

☑ Reviewed (see reverse); no changes since 4 / 07
☐ No changes since documentation of ___/___/___ except:

DEVELOPMENT:

☑ Up on elbows in prone; midline play
☑ Unfisted; follow/tracks 360°
☑ Coos, localizes sound
☑ Laughs; head erect in supported sitting

ANTICIPATORY GUIDANCE (Circle if H/O given):

☒ Car/infant seat; falls; walker safety; ~~water safety~~
☑ Rolling/reaching; sleeping position
☑ Teething; URI care
☑ Formula/breast; cereal (introduction of solids) #2

IMMUNIZATIONS DUE: Prevnar, Pediarix

PREVIOUS SHOT REACTIONS: HIB, Rotavirus

PROBLEMS:
① spot on head
② fussy

Pain Assessment: ⓪ 1 2 3 4 5 6 7 8 9 10
Nutritional Risk: ☒ No ☐ Yes - See Form

History /VS taken by (signature): B Burmoodeo
-printed items are completed as medically indicated.

PHYSICAL EXAMINATION:

Ht: 23# Wt: 14#2oz HC: 16 1/4 Birth Wt: 5#11oz
{T: 98.6 (R) P: 132 R: 32 BP: — }

ORGAN SYSTEM (describe abnormals below)	Normal	Abnl
GEN/CONST: body habitus, nutrition, grooming	☑	☐
SKIN: inspect/palpate, rash, nevi, hemangioma, cafe au lait	☑	☐
HEAD: shape, symmetry, AF, PF, sutures	☑	☐
EYES: conjunctiva, lids, pupils, irises, red reflex	☑	☐
EARS/NOSE: ext. ear, canals, pneumatic otoscopy, TM's, nares, nasal mucosa, septum	☑	☐
MOUTH: lips, gums, palate, buccal mucosa, pharynx	☐	☑
NECK: symmetry, masses, tracheal position, torticollis	☐	☐
CHEST: breast hypertrophy, symmetry, palpation	☐	☐
LUNGS: resp. effort, percussion, auscultation	☑	☐
CV: palpation-PMI, S1, S2, extra sounds, murmurs, femoral pulses, brachial pulses, bruits	☑	☐
GI/ABD: palpation, auscultation, masses, liver, spleen, hernias, umbilicus, anus	☑	☐
GU: bladder, hernia, penis, scrotum, circumcision, ext. female genitalia	☐	☐
LYMPH NODES: neck, axillae, groin, other	☑	☐
MUSCULOSKEL: hip abduction/dislocation, creases, digits/nails, symmetry, masses, deformity	☑	☐
NEURO: Moro, grasp, tone, DTR's, cranial nerves/facial symmetry	☑	☐

ABNORMAL FINDINGS:
(L) ear slightly red (H) Mobile

PROBLEMS / PLANS / INSTRUCTIONS:
① 4m wcc
② Thrush - Nystatin 1ml qid x 7days if fussy in 3-11 days - RTC or cvt

Labs: _____
Immunizations given: ☐ NO ☒ YES - see Imm. Flowsheet
INFORMED CONSENT DISCUSSED: ☐ YES ☐ N/A
Patient Education: ☐ NO ☐ YES _____ ☐ H/O given
Medication instructions given: ☐ YES ☐ N/A
RTC:
Signature: [signature]

Name: [redacted] Exam Date: 8.9.07 DOB: 4.6.07

DEVELOPMENT / ANTICIPATORY GUIDANCE PROMPTS:

SAFETY / BEHAVIOR:

Falls: Developing motor skills. Crib/playpen are safe areas.
Walker: Not recommended; increases mobility before the child
Rolling / Reaching: never leave infant unattended on elevated surface. Avoid small objects which might be swallowed.
Sleeping position: on side or back to decrease risk of SIDS.

ILLNESS:

Fever: Temp ≥ 101° may be significant; parent should call office. Tell parent approp. acetaminophen dose.
Gastroenteritis: clear liquids (Pedialyte) for 12 - 24 hrs, then advance diet as tolerated. Call if elevated temp, bloody stools, or signs/sx of dehydration. Breastfed infants may continue to nurse if tolerating it well.

FEEDINGS:

Formula: 4 - 7 oz., 5 x/day. No bottles in bed with baby.
Breast: Feed on demand, usually 5+ times per day.
Solids: May choose to start cereal-rice, oat, or barley - 1 tsp. mixed with 2 - 3 tsp. of formula or breast milk. Feed from from spoon; NO INFANT FEEDERS!

REVIEW OF SYSTEMS

(mark box if reviewed; circle abnormals)

☒ **REVIEWED ALL**

- ☐ **CONSTITUTIONAL:** development, fever, fatigue, appetite, weight Δ
- ☐ **INTEGUMENT:** rashes, lumps, birthmarks, lesions, itch, nails, breasts
- ☐ **EYES:** vision, strabismus, infection, redness, pain, glasses/contacts
- ☐ **EARS/NOSE/MOUTH/THROAT:** hearing, infections, pain, drainage, bleeding, obstruction, snoring, smell, dentition, palate, tongue, ulcers
- ☐ **RESP:** wheeze, cough, apnea, choking, SOB, pain, hemoptysis
- ☐ **CV:** BP, murmur, rheumatic fever, exercise tolerance, tachycardia, irreg. heart rate, chest pain, edema
- ☐ **GI:** abd. pain, bleeding, ulcers, jaundice, reflux, anorexia, nausea, vomiting, constipation, diarrhea, IBS, bloating, heartburn
- ☐ **GU:** infection, nocturia, urgency, frequency, blood in urine, incontinence, dysmenorrhea, spotting, ureteral reflux
- ☐ **MUSCULOSKELETAL:** deformities, gait, joint swelling, arthritis, extremity pain, dislocations, fractures, neck injury, back problems
- ☐ **ENDOCRINE:** growth, polyuria, polydipsia, menstrual problems, thyroid problems, blood sugar
- ☐ **NEURO:** seizures, HA's, speech, educational achievement, coordination, balance, tremor, weakness
- ☐ **HEME/LYMPH:** anemia, lymph nodes, bleeding, bruising
- ☐ **ALLERGIC/IMMUNO:** allergic rhinitis/conjunctivitis, freq. infections
- ☐ **PSYCH:** stress, anxiety, nerves, depression, sleep, work, family

ABN:

FAMILY HISTORY

Stroke/heart disease
Sickle Cell:
Hip Problems:
Scoliosis:
Lazy Eye:
Kidney Disease:
Deafness:
SIDS/Early Infancy Deaths:
Allergies/Asthma/Eczema:
Cyctic Fibrosis:
Diabetes:
HTN:
Melanoma:
TB:
Anemia/Bleeding:
Seizures:

PAST MEDICAL HISTORY

Birth Hx.:
Hospitalizations:
Fractures/Sutures:
Childhood illnesses:
Surgeries: (esp. removal of a paired organ)

SOCIAL HISTORY:

Parents:
Siblings:
Living arrangements:
Child Care arrangements:
Smokers in home:
Cultural practices/beliefs which may affect healthcare:
Other:

VACCINE ADMINISTRATION RECORD

Patient Name [redacted]

Birthdate 4-6-07

OSF Medical Group – Pontiac
Steven Norris, MD/Rebecca Proehl, MD/Mary Jo Krall, RN, CNP
Nancy White, RN, CNP 2500 W. Reynolds Street, Pontiac, IL

"I have been provided a copy, and have read or have had explained to me, information about the diseases and the vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) below be given to me or to the person named above (for whom I am authorized to make this request)."

I also give my permission for the information on this sheet to be released to my County Health Department.

VACCINE	DATE m/d/y	AGE	SITE	MANUFACTURER/ LOT #	HANDOUT DATE	INITIALS	SIGNATURE OF PARENT/GUARDIAN
Prevnar 1	6-8-07	2mo	RL	VFC Wyeth PREVNAR #B08689H exp 6/08	9/30/02	Bw	x Michelle Bobins
Prevnar 2	8-9-07	4 mo		VFC LED PREVNAR #B26510A exp 8/30/08	9/30/02	BB	x MLB
Prevnar 3					9/30/02		
Prevnar 4					9/30/02		
DTaP/IPV/HepB 1	6-8-07	2mo	LL	VFC SKB PEDIARIX AC21B069AA exp 10/11/08	7/30/01 1/1/00 7/11/01	Bw	x Michelle Bobins
DTaP/IPV/HepB 2	8-9-07	4 mon	L	VFC GSK PEDIARIX #AC21B09AA exp 3/28/09	7/30/01 1/1/00 7/11/01	BB	x MLB
DTaP/IPV/HepB 3					7/30/01 1/1/00 7/11/01		
DTaP 4					7/30/01		
DTaP 5					7/30/01		
IPV 4					1/1/2000		
Rotavirus 1	6-8-07	2mo	Oral	VFC MSD ROTATEQ #1032F exp 7/12/2008	4/12/06	Bw	x Michelle Bobins
Rotavirus 2	8-9-07	4 mo	oral	VFC MSD ROTATEQ #0508U exp1/10/09	4/12/06	BB	x MLB
Rotavirus 3					4/12/06		

"I have been provided a copy, and have read or have had explained to me, information about the diseases and the vaccines listed below. I have had a chanc to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) below be given to me or to the person named above (for whom I am authorized to make this request)."

I also give my permission for the information on this sheet to be released to my County Health Department.

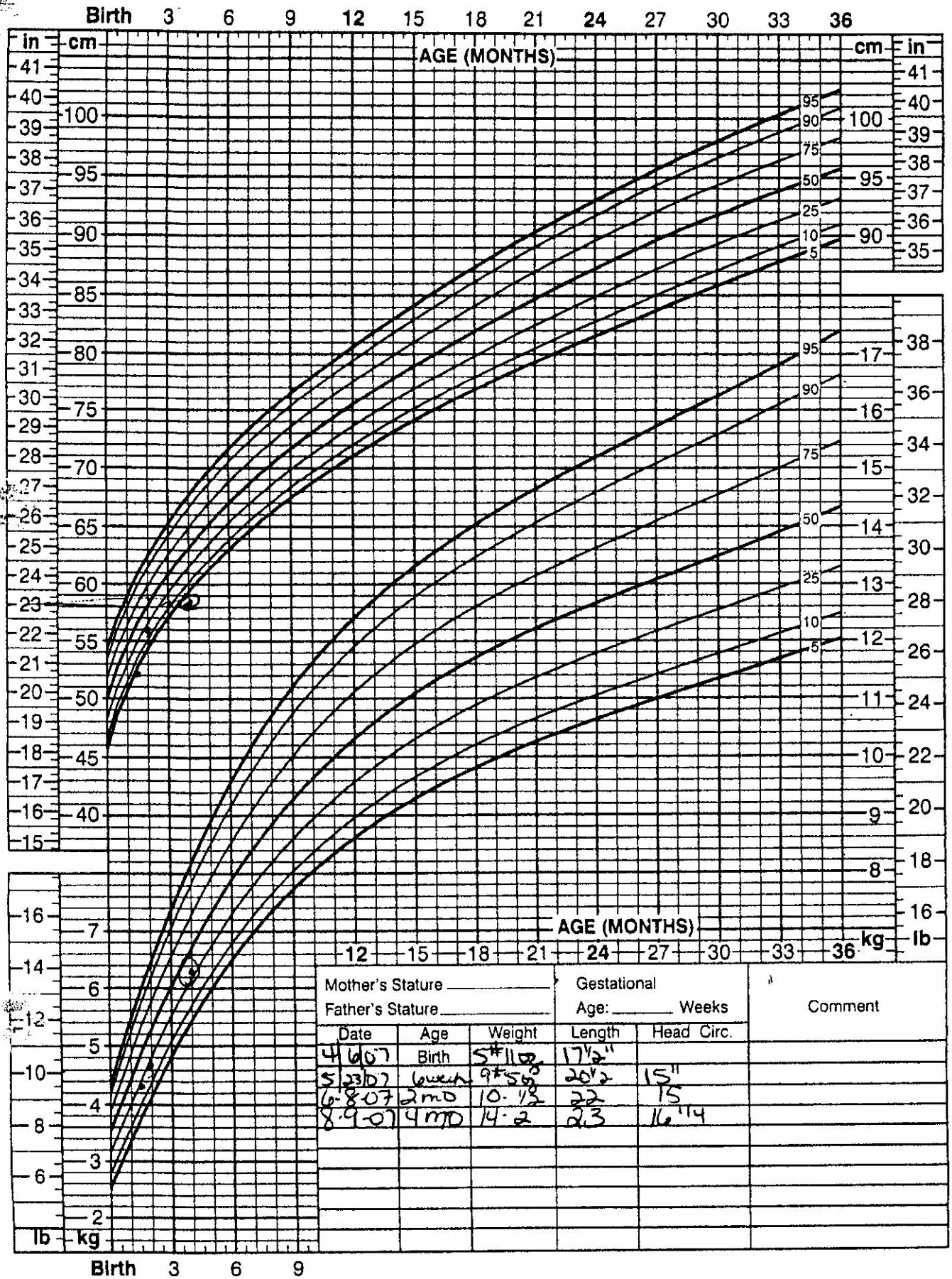
HIB 1	6-8-07	2mo	RL	VFC MSD Pedvax HIB #0889R exp 6/9/08	12/16/98	Bu	[redacted]
HIB 2	8-9-07	4 mo	L	VFC MERCK HIB #1274F exp 5/15/09	12/16/98	BB	[redacted]
HIB 3					12/16/98		
HIB 4 (if needed)					12/16/98		
MMR 1					1/15/03		
MMR 2					1/15/03		
Varicella					12/16/98		
Proquad					1/15/03 12/16/98		
dT					6/10/94		
Menactra					10/7/05		
Tdap					9/22/05		
Hepatitis A 1					1/9/06		
Hepatitis A 2					1/9/06		

Boys, birth to 36 months

Name [redacted]

LENGTH FOR AGE AND WEIGHT FOR AGE PERCENTILES

Record #_____



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
4/6/07	Birth	5#11oz	17½"		
5/23/07	6 week	9#5oz	20½	15"	
6-8-07	2mo	10-12	22	15	
8-9-07	4mo	14-2	23	16"14	

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Source: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

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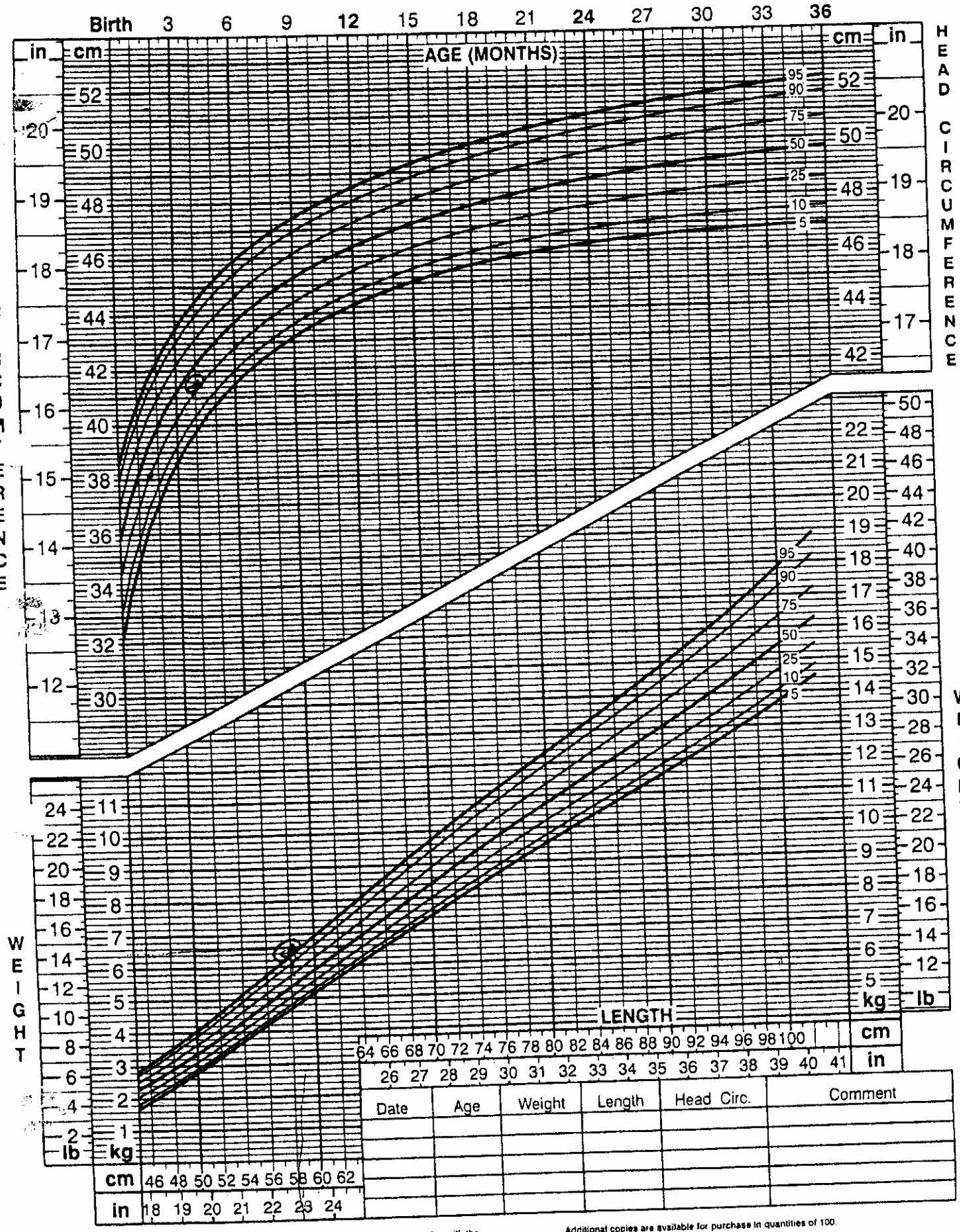
American Academy of Pediatrics, PO Box 747,
Elk Grove Village, IL 60009-0747
Web site — http://www.aap.org. Minimum order 100.

Boys, Birth to 36 months

Name [redacted]

HEAD CIRCUMFERENCE FOR AGE AND WEIGHT FOR LENGTH PERCENTILES

Record #_____



Date	Age	Weight	Length	Head Circ.	Comment

CDC

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Source: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

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Elk Grove Village, IL 60009-0747
Web site — http://www.aap.org. Minimum order 100.

HE0303

CONTACT SHEET

Livingston County Coroner
P.O. Box 527
Pontiac, IL 61764

Initial Contact: 10-23-09

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