CONFIDENTIAL MEDICAL RECORD

Agency Stamp

NEW YORK CITY DEPARTMENT OF HEALTH
BUREAU OF DAY CARE
CHILDREN'S MEDICAL RECORD

NEW ADMISSION RECORD

Date of Admission: ____/____/____

(Last) (First) (Middle) **NAME:**	**SEX** ❑ F ❑ M	**DATE OF BIRTH:** ____/____/____ **Birth weight:** ________________ **Place of Birth:** ______________
(No.) (Street) (City/Boro) (State) (Zip) **ADDRESS:**		

PHYSICIAN'S REPORT TO DAY CARE

Significant Family Medical/Social History
Explain Those Marked

- ❑ Vision ______________________________
- ❑ Hearing ______________________________
- ❑ TB ______________________________
- ❑ Chronic Illnesses ______________________________
- ❑ Social Concerns ______________________________
- ❑ Exposure to Violence ______________________________
- ❑ Other ______________________________

Birth History
- ❑ Normal
- ❑ High Risk or Problems- Specify ________

Past Medical History
- ❑ Normal
- ❑ High Risk or Problems- Specify ______

ALLERGIES:
- ❑ NONE
- ❑ FOOD ______________________________
- ❑ MEDICINE ______________________________
- ❑ OTHER ______________________________

DEVELOPMENTAL OBSERVATION Check "Yes" or "No" for appropriate ages. If more than 2 "No's" or any boxed item is marked in child's age category, indicate follow-up or action taken in the Sections Diagnoses, Problems and Plan on back of form.

BY 6 MONTHS
Y N
- ☐☐ Imitates vocalizing
- ☐☐ Turns to voice
- ☐☐ Rolls over
- ☐☐ Reaches (each hand)
- ☐☐ Cuddles

❑ AVOIDS EYE CONTACT

BY 12 MONTHS
Y N
- ☐☐ Stands alone 2 secs
- ☐☐ Bangs two blocks
- ☐☐ Says "Mama/Dada" specifically
- ☐☐ Responds to "NO"
- ☐☐ Plays patty cake or waves "bye-bye"

❑ AVOIDS EYE CONTACT
❑ CONCERN THAT CHILD CAN'T HEAR
❑ TUNES OUT

BY 18 MONTHS
Y N
- ☐☐ Imitates household chores (sweeping)
- ☐☐ Says 4 words besides "Mama/Dada"
- ☐☐ Points to one body part "show me your nose"
- ☐☐ Drinks from a cup
- ☐☐ Scribbles

❑ AVOIDS EYE CONTACT
❑ TOE WALKING

BY 2 YEARS
Y N
- ☐☐ Kicks ball forward
- ☐☐ Combines 2 words
- ☐☐ Strangers understand half child's speech
- ☐☐ Points to 6 named body parts (nose, eyes…)
- ☐☐ Names 1 animal picture
- ☐☐ Takes off clothing (other than hat)

PERSISTANT
❑ ROCKING
❑ HEADBANGING
❑ HANDFLAPPING

BY 3 YEARS
Y N
- ☐☐ Can hold 2-3 sentence conversation
- ☐☐ Names 4 animal pictures
- ☐☐ Knows 2 animal actions which flies, meows, etc.
- ☐☐ Understands what to do when tired, cold or hungry (1 out of 3)
- ☐☐ Imitates a vertical line
- ☐☐ Washes and dries hands

❑ ECHOLALIA (repeating what was just said)

BY 4 YEARS
Y N
- ☐☐ Knows first and last names
- ☐☐ Understands what to do when tired, cold or hungry (2 out of 3)
- ☐☐ Plays interactive games (like tag)
- ☐☐ Walks up stairs not holding on
- ☐☐ Toilet trained/night

BY 5 YEARS
Y N
- ☐☐ Throws a ball overhand
- ☐☐ Draws a three-part person
- ☐☐ Copies a cross
- ☐☐ Names four colors
- ☐☐ Dresses without supervision

COMPLETE PHYSICAL EXAMINATION

Height ____________in __________(%'ile)

Head Circumference (up to 24 mos) _________in __________(%'ile)

Weight ______________lbs __________(%'ile)

Blood Pressure (after 3 years of age)_______/________

Physical Examination:
- ❑ Normal
- ❑ Abnormal, specify: ______________________________

318KA-1 (REV. 8/97)

Child's Name: ______________________ DOB ____/____/____ **NEW ADMISSION RECORD**

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit **Or** - - - - - - - - - - - Hemoglobin		Hct. % - - - - - - - Hb gms%
Newborn Screening **or** - - - - - - - - - - - Hemoglobin Electrphoresis		
Lead Risk Assesment - - - - - - - - - - - - Lead Screening (Venous preferred)		
Tuberculin Test (PPD Mantoux)*		
Vision Screening		
Hearing Screening		
Urinalysis (Optional)		
OTHER TESTS *(Specify)* __________		
__________		
__________		

* See recommended schedule: Not required for all children.

DENTAL ASSESSMENT *Date:* ____/____/____

1. Examiner ☐ MD ☐ DDS ☐ Dental Hygienist

☐ Other Health Care Professional *(Specify)* ______________

2. Does the child sleep with a bottle? ☐ Yes ☐ No

3. Findings
- **A. No Visible Problems** .... ☐
  (Clean mouth, no visible cavities, healthy gums)
- **B. Some Problems Detected** .... ☐
  (Cavities, inflamed gums, open bite, malocclusion)
- **C. Severe Problems** .... ☐
  (Baby bottle tooth decay; extensive; abscesses)
- **D. Other** *(Specify):* .... ☐

Referral Suggested if B, C, or D is checked

4. Has the child been referred to Dentist? ☐ Yes ☐ No

NUTRITIONAL UPDATE

Up to age 1 year: Is the child on?

Formula? ☐ No ☐ Yes
Breast Milk? ☐ No ☐ Yes
Solid foods? ☐ No ☐ Yes

1 year and above:

Is child bottle fed? ☐ No ☐ Yes
Type of diet? ______________

Unusual dietary habit? ☐ No ☐ Yes, specify ______________

____

Dietary restrictions? ☐ No ☐ Yes, specify ______________

____

IMMUNIZATION HISTORY

DATE IMMUNIZATION GIVEN

	1st	2nd	3rd	4th	5th
DTP					
DT					
DtaP					
Hib					
OPV/IPV					
Hep B					
MMR					
Varicella					
Other, Specify:					

DIAGNOSIS/PROBLEMS/CLINICAL IMPRESSIONS

(Include all chronic conditions or conditions/findings needing follow-up)

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____
2. Follow-up Needed ☐ Yes ☐ No
   (Specify referral and date) ______________
3. ______________
4. ______________
5. ______________

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes ☐ No ☐

2. Special recommendations for child? Specify treatments provided or, Recommended evaluations. Does child require special education Or early intervention? ______________

____

Name/Address Stamp, if available:

______________ Signature ______________ Date of Exam.

______________ Name (PLEASE PRINT) ______________ Degree:

License No. ______________ ______________ Telephone No.

Address ______________