

CONFIDENTIAL MEDICAL RECORD

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

Agency Stamp

NEW ADMISSION RECORD

Date of Admission: ____/____/____

(Last)	(First)	(Middle)		SEX	DATE OF BIRTH: ____/____/____
NAME:			<input type="checkbox"/> F	Birth weight: _____	
			<input type="checkbox"/> M	Place of Birth: _____	
(No.)	(Street)	(City/Boro)		(State)	(Zip)
ADDRESS:					

PHYSICIAN'S REPORT TO DAY CARE

<p>Significant Family Medical/Social History <i>Explain Those Marked</i></p> <p><input type="checkbox"/> Vision _____</p> <p><input type="checkbox"/> Hearing _____</p> <p><input type="checkbox"/> TB _____</p> <p><input type="checkbox"/> Chronic Illnesses _____</p> <p><input type="checkbox"/> Social Concerns _____</p> <p><input type="checkbox"/> Exposure to Violence _____</p> <p><input type="checkbox"/> Other _____</p>	<p>Birth History</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High Risk or Problems- Specify _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>ALLERGIES:</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> FOOD _____</p> <p><input type="checkbox"/> MEDICINE _____</p> <p><input type="checkbox"/> OTHER _____</p>	<p>Past Medical History</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High Risk or Problems- Specify _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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	BY 12 MONTHS	BY 18 MONTHS	BY 2 YEARS	BY 3 YEARS
<p>Y N</p> <p><input type="checkbox"/> Imitates vocalizing</p> <p><input type="checkbox"/> Turns to voice</p> <p><input type="checkbox"/> Rolls over</p> <p><input type="checkbox"/> Reaches (each hand)</p> <p><input type="checkbox"/> Cuddles</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT </div>	<p>Y N</p> <p><input type="checkbox"/> Stands alone 2 secs</p> <p><input type="checkbox"/> Bangs two blocks</p> <p><input type="checkbox"/> Says "Mama/Dada" specifically</p> <p><input type="checkbox"/> Responds to "NO"</p> <p><input type="checkbox"/> Plays patty cake or waves "bye-bye"</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR TUNES OUT </div>	<p>Y N</p> <p><input type="checkbox"/> Imitates household chores (sweeping)</p> <p><input type="checkbox"/> Says 4 words besides "Mama/Dada"</p> <p><input type="checkbox"/> Points to one body part "show me your nose"</p> <p><input type="checkbox"/> Drinks from a cup</p> <p><input type="checkbox"/> Scribbles</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> TOE WALKING </div>	<p>Y N</p> <p><input type="checkbox"/> Kicks ball forward</p> <p><input type="checkbox"/> Combines 2 words</p> <p><input type="checkbox"/> Strangers understand half child's speech</p> <p><input type="checkbox"/> Points to 6 named body parts (nose, eyes...)</p> <p><input type="checkbox"/> Names 1 animal picture</p> <p><input type="checkbox"/> Takes off clothing (other than hat)</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> PERSISTANT <input type="checkbox"/> ROCKING <input type="checkbox"/> HEADBANGING <input type="checkbox"/> HANDFLAPPING </div>	<p>Y N</p> <p><input type="checkbox"/> Can hold 2-3 sentence conversation</p> <p><input type="checkbox"/> Names 4 animal pictures</p> <p><input type="checkbox"/> Knows 2 animal actions which flies, meows, etc.</p> <p><input type="checkbox"/> Understands what to do when tired, cold or hungry (1 out of 3)</p> <p><input type="checkbox"/> Imitates a vertical line</p> <p><input type="checkbox"/> Washes and dries hands</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> ECHOLALIA (repeating what was just said) </div>
<p>BY 4 YEARS</p> <p>Y N</p> <p><input type="checkbox"/> Knows first and last names</p> <p><input type="checkbox"/> Understands what to do when tired, cold or hungry (2 out of 3)</p> <p><input type="checkbox"/> Plays interactive games (like tag)</p> <p><input type="checkbox"/> Walks up stairs not holding on</p> <p><input type="checkbox"/> Toilet trained/night</p>	<p>BY 5 YEARS</p> <p>Y N</p> <p><input type="checkbox"/> Throws a ball overhand</p> <p><input type="checkbox"/> Draws a three-part person</p> <p><input type="checkbox"/> Copies a cross</p> <p><input type="checkbox"/> Names four colors</p> <p><input type="checkbox"/> Dresses without supervision</p>			

COMPLETE PHYSICAL EXAMINATION

<p>Height _____ in _____ (%'ile)</p> <p>Head Circumference (up to 24 mos) _____ in _____ (%'ile)</p> <p>Weight _____ lbs _____ (%'ile)</p> <p>Blood Pressure (after 3 years of age) _____ / _____</p>	<p>Physical Examination:</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Abnormal, specify: _____</p> <p>_____</p> <p>_____</p>
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SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit Or ----- Hemoglobin		Hct. % ----- Hb gms%
Newborn Screening or ----- Hemoglobin Electrophoresis		
Lead Risk Assessment ----- 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? 1 year and above:
- | | |
|---|---|
| Formula? <input type="checkbox"/> No <input type="checkbox"/> Yes | Is child bottle fed? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Breast Milk? <input type="checkbox"/> No <input type="checkbox"/> Yes | Type of diet? _____ |
| Solid foods? <input type="checkbox"/> No <input type="checkbox"/> Yes | |

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)
- _____
 - _____
 - _____
 - _____
 - _____

PLAN (Therapies, Referrals, F/U)

- Next Appointment Date ____/____/____
- Follow-up Needed Yes No
 (Specify referral and date) _____
- _____
- _____
- _____

RECOMMENDATIONS

- Approve participation in early childhood program/day care? Yes No
- 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 _____