

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

PHYSICIAN'S REPORT TO DAY CARE

Significant Family Medical/Social History <i>Explain Those Marked</i> <input type="checkbox"/> Vision _____ <input type="checkbox"/> Hearing _____ <input type="checkbox"/> TB _____ <input type="checkbox"/> Chronic Illnesses _____ <input type="checkbox"/> Social Concerns _____ <input type="checkbox"/> Exposure to Violence _____ <input type="checkbox"/> Other _____	Birth History <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problem- Specify _____ _____ _____ _____ ALLERGIES: <input type="checkbox"/> NONE <input type="checkbox"/> FOOD _____ <input type="checkbox"/> MEDICINE _____ <input type="checkbox"/> OTHER _____	Past Medical History <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problems- Specify _____ _____ _____ _____
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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 Y N <input type="checkbox"/> Imitates vocalizing <input type="checkbox"/> Turns to voice <input type="checkbox"/> Rolls over <input type="checkbox"/> Reaches (each hand) <input type="checkbox"/> Cuddles <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <input type="checkbox"/> AVOIDS EYE CONTACT </div>	BY 12 MONTHS Y N <input type="checkbox"/> Stands alone 2 secs <input type="checkbox"/> Bangs two blocks <input type="checkbox"/> Says "Mama/Dada" specifically <input type="checkbox"/> Responds to "NO" <input type="checkbox"/> Plays patty cake or waves "bye-bye" <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR <input type="checkbox"/> TUNES OUT </div>	BY 18 MONTHS Y N <input type="checkbox"/> Imitates household chore (sweeping) <input type="checkbox"/> Says 4 words besides "Mama/Dada" <input type="checkbox"/> Points to one body part "show me your nose" <input type="checkbox"/> Drinks from a cup <input type="checkbox"/> Scribbles <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> TOE WALKING </div>	BY 2 YEARS Y N <input type="checkbox"/> Kicks ball forward <input type="checkbox"/> Combines 2 words <input type="checkbox"/> Stranger's understand half child's speech <input type="checkbox"/> Points to 8 named body parts (nose, eyes...) <input type="checkbox"/> Names 1 animal picture <input type="checkbox"/> Takes off clothing (other than hat) <div style="border: 1px solid black; padding: 2px; width: fit-content;"> PERSISTANT <input type="checkbox"/> ROCKING <input type="checkbox"/> HEADBANGING <input type="checkbox"/> HANDFLAPPING </div>	BY 3 YEARS Y N <input type="checkbox"/> Can hold 2-3 sentence conversation <input type="checkbox"/> Names 4 animal pictures <input type="checkbox"/> Knows 2 animal actions which first meows, etc <input type="checkbox"/> Understands what to do when tired, cold or hungry (1 out of 3) <input type="checkbox"/> Imitates a vertical line <input type="checkbox"/> Washes and dries hands <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <input type="checkbox"/> ECHOLALIA (repeating what was just said) </div>
BY 4 YEARS Y N <input type="checkbox"/> Knows first and last names <input type="checkbox"/> Understands what to do when tired, cold or hungry (2 out of 3) <input type="checkbox"/> Plays interactive games (like tag) <input type="checkbox"/> Walks up stairs not holding on <input type="checkbox"/> Toilet trained/night	BY 5 YEARS Y N <input type="checkbox"/> Throws a ball overhand <input type="checkbox"/> Draws a three-part person <input type="checkbox"/> Copies a cross <input type="checkbox"/> Names four colors <input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, specify: _____ _____ _____
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Child's Name: _____ DOB: ____/____/____

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS	
		Hct	%
Hematocrit Or Hemoglobin		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? No Yes
 Breast Milk? No Yes
 Solid foods? No Yes

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					
Vaccella					
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 _____