

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

**PHYSICIAN'S REPORT TO DAY CARE**

<p><b>Significant Family Medical/Social History</b> <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><b>Birth History</b></p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High Risk or Problems- Specify _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>ALLERGIES:</b></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><b>Past Medical History</b></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.

<b>BY 6 MONTHS</b>	<b>BY 12 MONTHS</b>	<b>BY 18 MONTHS</b>	<b>BY 2 YEARS</b>	<b>BY 3 YEARS</b>
<p><b>Y N</b></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><b>Y N</b></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><b>Y N</b></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><b>Y N</b></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; text-align: center;">             PERSISTANT  <input type="checkbox"/> ROCKING  <input type="checkbox"/> HEADBANGING  <input type="checkbox"/> HANDFLAPPING         </div>	<p><b>Y N</b></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>
<b>BY 4 YEARS</b>	<b>BY 5 YEARS</b>			
<p><b>Y N</b></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><b>Y N</b></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)		
<b>OTHER TESTS (Specify)</b>		
_____		
_____		
_____		

\* 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					
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 \_\_\_\_\_