

CONFIDENTIAL MEDICAL RECORD

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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 second hand smoke in home _____</p> <p><input type="checkbox"/> Exposure to Violence _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Other _____</p>	<p>Birth History <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High Risk or Problems – Specify _____</p> <p>_____</p> <p>_____</p>	<p>Past Medical History <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High Risk or Problems – Specify _____</p> <p>_____</p> <p>_____</p>
		<p>ALLERGIES: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> FOOD _____</p> <p><input type="checkbox"/> MEDICINE _____</p> <p><input type="checkbox"/> OTHER _____</p>

ASTHMA

In the past 12 months has the child been to the ED or been admitted to the hospital for breathing problems?
 Yes No

Has the child ever been diagnosed with asthma?
 Yes No

If Yes, Indicate Severity:
 Mild Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

In the past 12 months has the child been prescribed any of the following medications for asthma or breathing problems?
 Inhaled corticosteroid Other controller medication
 B₂-agonist Oral steroid No medication

If Yes to any of the above, complete and attach an **Asthma Action Plan (AAP)**.
 (Call 311 to order blank AAPs).

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	BY 4 YEARS
<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Imitates vocalizing</p> <p><input type="checkbox"/> <input type="checkbox"/> Turns to voice</p> <p><input type="checkbox"/> <input type="checkbox"/> Rolls over</p> <p><input type="checkbox"/> <input type="checkbox"/> Reaches (each hand)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cuddles</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> AVOIDS EYE CONTACT</p> </div>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Stands alone 2 secs</p> <p><input type="checkbox"/> <input type="checkbox"/> Bangs two blocks</p> <p><input type="checkbox"/> <input type="checkbox"/> Says "Mama/Dada" specifically</p> <p><input type="checkbox"/> <input type="checkbox"/> Responds to "NO"</p> <p><input type="checkbox"/> <input type="checkbox"/> Plays patty cake or waves "bye-bye"</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> AVOIDS EYE CONTACT</p> <p><input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR</p> <p><input type="checkbox"/> TUNES OUT</p> </div>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Imitates household chores (sweeping)</p> <p><input type="checkbox"/> <input type="checkbox"/> Says 4 words besides "Mama/Dada"</p> <p><input type="checkbox"/> <input type="checkbox"/> Points to one body part "show me your nose"</p> <p><input type="checkbox"/> <input type="checkbox"/> Drinks from a cup</p> <p><input type="checkbox"/> <input type="checkbox"/> Scribbles</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> AVOIDS EYE CONTACT</p> <p><input type="checkbox"/> TOE WALKING</p> </div>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Kicks ball forward</p> <p><input type="checkbox"/> <input type="checkbox"/> Combines 2 words</p> <p><input type="checkbox"/> <input type="checkbox"/> Strangers understand half child's speech</p> <p><input type="checkbox"/> <input type="checkbox"/> Points to 6 named body parts (nose, eyes...)</p> <p><input type="checkbox"/> <input type="checkbox"/> Names 1 animal picture</p> <p><input type="checkbox"/> <input type="checkbox"/> Takes off clothing (other than hat)</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>PERSISTENT</p> <p><input type="checkbox"/> ROCKING</p> <p><input type="checkbox"/> HEADBANGING</p> <p><input type="checkbox"/> HANDFLAPPING</p> </div>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Can hold 2-3 sentence conversation</p> <p><input type="checkbox"/> <input type="checkbox"/> Names 4 animal pictures</p> <p><input type="checkbox"/> <input type="checkbox"/> Knows 2 animal actions: which flies, meows etc.</p> <p><input type="checkbox"/> <input type="checkbox"/> Understands what to do when tired, cold or hungry (1 out of 3)</p> <p><input type="checkbox"/> <input type="checkbox"/> Imitates a vertical line</p> <p><input type="checkbox"/> <input type="checkbox"/> Washes and dries hands</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> AVOIDS INTERACTIVE PLAY</p> </div>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Knows first and last names</p> <p><input type="checkbox"/> <input type="checkbox"/> Understands what to do when tired, cold or hungry (2 out of 3)</p> <p><input type="checkbox"/> <input type="checkbox"/> Plays interactive games (like tag)</p> <p><input type="checkbox"/> <input type="checkbox"/> Walks up stairs not holding on</p> <p><input type="checkbox"/> <input type="checkbox"/> Toilet trained/night</p> <p>BY 5 YEARS</p> <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Throws a ball overhand</p> <p><input type="checkbox"/> <input type="checkbox"/> Draws a three-part person</p> <p><input type="checkbox"/> <input type="checkbox"/> Copies a cross</p> <p><input type="checkbox"/> <input type="checkbox"/> Names four colors</p> <p><input type="checkbox"/> <input type="checkbox"/> Dresses without supervision</p>

COMPLETE PHYSICAL EXAMINATION

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