

**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)	<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**

<b>Significant Family Medical/Social History</b> <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 second hand smoke in home _____ <input type="checkbox"/> Exposure to Violence _____ <input type="checkbox"/> Other _____	<b>Birth History</b> <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problems— Specify _____ _____ _____	<b>Past Medical History</b> <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problems— Specify _____ _____ _____
<b>ALLERGIES:</b> <input type="checkbox"/> NONE <input type="checkbox"/> FOOD _____ <input type="checkbox"/> MEDICINE _____ <input type="checkbox"/> 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	BY 12 MONTHS	BY 18 MONTHS	BY 2 YEARS	BY 3 YEARS	BY 4 YEARS
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; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT                     </div>	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; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT  <input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR  <input type="checkbox"/> TUNES OUT                     </div>	Y N <input type="checkbox"/> Imitates household chores (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; margin-top: 5px;"> <input type="checkbox"/> AVOIDS EYE CONTACT  <input type="checkbox"/> TOE WALKING                     </div>	Y N <input type="checkbox"/> Kicks ball forward <input type="checkbox"/> Combines 2 words <input type="checkbox"/> Strangers understand half child's speech <input type="checkbox"/> Points to 6 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; margin-top: 5px;">                         PERSISTENT  <input type="checkbox"/> ROCKING  <input type="checkbox"/> HEADBANGING  <input type="checkbox"/> HANDFLAPPING                     </div>	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 flies, 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; margin-top: 5px;"> <input type="checkbox"/> ECHOLALIA (repeating what was just said)                     </div>	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 <b>BY 5 YEARS</b> 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

<b>COMPLETE PHYSICAL EXAMINATION</b>	
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: _____ _____ _____

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NEW ADMISSION RECORD**

318KA-1 (REV 2/04)

**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 Screening (PPD Mantoux)*		
Vision Screening		NL AB Red Reflex <input type="checkbox"/> <input type="checkbox"/> Cover Test <input type="checkbox"/> <input type="checkbox"/>
Hearing Screening		
OTHER TESTS (Specify)		

**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 cavities; 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 habits?  No  Yes, specify \_\_\_\_\_

Dietary restrictions?  No  Yes, specify \_\_\_\_\_

\* See recommended schedule: Not required at entry or for all children.

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
DTP					
DT					
DTaP					
Hib					
OPV/IPV					
Hep B					
MMR					
Varicella					
Pneumococcal					

**DIAGNOSES/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 \_\_\_\_\_