# CONFIDENTIAL MEDICAL RECORD

Agency Stamp

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

## NEW ADMISSION RECORD

Date of Admission: ____/____/____

| (Last) | (First) | (Middle) | SEX | DATE OF BIRTH: ____/____/____ |
|---|---|---|---|---|
| NAME: | | | ❑ F ❑ M | Birth weight: _____ Place of Birth: _____ |

| (No.) | (Street) | (City/Boro) | (State) | (Zip) |
|---|---|---|---|---|
| ADDRESS: | | | | |

## PHYSICIAN'S REPORT TO DAY CARE

**Significant Family Medical/Social History**
*Explain Those Marked*

- ❑ Vision _____
- ❑ Hearing _____
- ❑ TB _____
- ❑ Chronic Illnesses _____
- ❑ Social Concerns _____
- ❑ Exposure to second hand smoke in home _____
- ❑ Exposure to Violence _____
- ❑ Diabetes _____
- ❑ Other _____

**Birth History** ❑ Normal
❑ High Risk or Problems – Specify _____

**Past Medical History** ❑ Normal
❑ High Risk or Problems – Specify _____

**ALLERGIES:** ❑ NONE
- ❑ FOOD _____
- ❑ MEDICINE _____
- ❑ OTHER _____

**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
❑ $B_2$-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**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Imitates vocalizing |
| ❑ | ❑ | Turns to voice |
| ❑ | ❑ | Rolls over |
| ❑ | ❑ | Reaches (each hand) |
| ❑ | ❑ | Cuddles |

❑ AVOIDS EYE CONTACT

**BY 12 MONTHS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Stands alone 2 secs |
| ❑ | ❑ | Bangs two blocks |
| ❑ | ❑ | Says "Mama/Dada" specifically |
| ❑ | ❑ | Responds to "NO" |
| ❑ | ❑ | Plays patty cake or waves "bye-bye" |

❑ AVOIDS EYE CONTACT
❑ CONCERN THAT CHILD CAN'T HEAR
❑ TUNES OUT

**BY 18 MONTHS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Imitates household chores (sweeping) |
| ❑ | ❑ | Says 4 words besides "Mama/Dada" |
| ❑ | ❑ | Points to one body part "show me your nose" |
| ❑ | ❑ | Drinks from a cup |
| ❑ | ❑ | Scribbles |

❑ AVOIDS EYE CONTACT
❑ TOE WALKING

**BY 2 YEARS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Kicks ball forward |
| ❑ | ❑ | Combines 2 words |
| ❑ | ❑ | Strangers understand half child's speech |
| ❑ | ❑ | Points to 6 named body parts (nose, eyes...) |
| ❑ | ❑ | Names 1 animal picture |
| ❑ | ❑ | Takes off clothing (other than hat) |

PERSISTENT
❑ ROCKING
❑ HEADBANGING
❑ HANDFLAPPING

**BY 3 YEARS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Can hold 2-3 sentence conversation |
| ❑ | ❑ | Names 4 animal pictures |
| ❑ | ❑ | Knows 2 animal actions: which flies, meows etc. |
| ❑ | ❑ | Understands what to do when tired, cold or hungry (1 out of 3) |
| ❑ | ❑ | Imitates a vertical line |
| ❑ | ❑ | Washes and dries hands |

❑ AVOIDS INTERACTIVE PLAY

**BY 4 YEARS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Knows first and last names |
| ❑ | ❑ | Understands what to do when tired, cold or hungry (2 out of 3) |
| ❑ | ❑ | Plays interactive games (like tag) |
| ❑ | ❑ | Walks up stairs not holding on |
| ❑ | ❑ | Toilet trained/night |

**BY 5 YEARS**

| Y | N | |
|---|---|---|
| ❑ | ❑ | Throws a ball overhand |
| ❑ | ❑ | Draws a three-part person |
| ❑ | ❑ | Copies a cross |
| ❑ | ❑ | Names four colors |
| ❑ | ❑ | Dresses without supervision |

**COMPLETE PHYSICAL EXAMINATION**

Height _____ in _____ (% 'ile)
Weight _____ lbs BMI _____ _____ (% 'ile)
Head Circumference (up to 24 mos) _____ in _____ (% 'ile)
Blood Pressure (after 3 years of age) _____ / _____

Physical examination: ❑ Normal
❑ Abnormal, specify: _____

Child's Name: _____ DOB____/____/____

**NEW ADMISSION RECORD**

318KA-1 (REV. 8/06)

**SCREENING TESTS AND RESULTS (See Schedule)**

| SCREENING TESTS | DATE DONE | RESULTS |
|---|---|---|
| Hematocrit<br>**or**<br>Hemoglobin | | Hct. %<br><br>Hb gms % |
| Newborn Screening<br>**or**<br>Hemoglobin Electrophoresis | | |
| Lead Risk Assessment | | |
| Lead Screening (Venous preferred) | | |
| Tuberculin Screening (PPD Mantoux)* | | |
| Vision Screening | | NL AB<br>Red Reflex ❑ ❑<br>Cover Test ❑ ❑ |
| **Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test. (ages 3–6 yrs)** | | FAR NEAR<br>Right ___/___ ___/___<br>Left ___/___ ___/___ PF<br>Both ___/___ ___/___ |
| Hearing Screening | | |
| **OTHER TESTS** *(Specify)* | | |
| | | |

* Not required at entry or 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 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* _____

**IMMUNIZATION HISTORY**

| | DATE IMMUNIZATION GIVEN | | | | |
|---|---|---|---|---|---|
| | 1st | 2nd | 3rd | 4th | 5th |
| Hep B | | | | | |
| DTaP | | | | | |
| Polio | | | | | |
| Hib | | | | | |
| PCV Pneumococcal | | | | | |
| MMR | | | | | |
| Varicella | | | | | |
| Hep A | | | | | |
| Influenza yearly 6-59 mos. | | | | | |
| Rotavirus | | | | | |
| Other | | | | | |

**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 _____