CONFIDENTIAL MEDICAL RECORD

Camp Topeinu
346 West 89th Street
New York, NY 10024

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

NEW ADMISSION RECORD

(Last)	(First)	(Middle)	SEX F M	DATE OF BIRTH: ___/___/___
NAME:				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. 6/06)

SCREENING TESTS AND RESULTS (See Schedule)

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