

CONFIDENTIAL MEDICAL RECORD

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BUREAU OF DAY CARE

CHILDREN'S MEDICAL RECORD

NYCDA
www.nycda.com
646-334-7426 Agency Stamp

NEW ADMISSION RECORD

Date of Admission: ___/___/___

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

PHYSICIAN'S REPORT TO DAY CARE

Significant Family Medical/Social History <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	Birth History <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problems— Specify _____	Past Medical History <input type="checkbox"/> Normal <input type="checkbox"/> High Risk or Problems— Specify _____
	ALLERGIES: <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 BY 5 YEARS 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

COMPLETE PHYSICAL EXAMINATION

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: _____ _____ _____
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Child's Name: _____

DOB ____/____/____

NEW ADMISSION RECORD

318KA-1 (REV. 2004)

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)		

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

DENTAL ASSESSMENT Date: ____/____/____

- Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____
- Does the child sleep with a bottle? Yes No
- 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
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)

- _____
- _____
- _____
- _____
- _____

PLAN (Therapies, Referrals, F/U)

- Next Appointment Date ____/____/____
- Follow-up Needed Yes No
(Specify referral end date) _____
- _____
- _____
- _____

RECOMMENDATIONS

- Approve participation in early childhood program/day care? Yes No
- 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 _____

Day Care Registration Form ("Blue Card")

OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

PHOTO OF CHILD

(required)

Child's Full Name:

Does your child have any allergies? Yes No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

Provider/Day Care Facility Name and Address: NYCDA www.nycnda.com 646-334-7436	CHILD'S FULL NAME:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
	CHILD'S HOME ADDRESS:	DATE OF BIRTH: _____
		HOME TELEPHONE NUMBER: _____
	DATE OF ACCEPTANCE:	DATE OF DISCHARGE:
	NAME OF PERSON APPLYING FOR CHILD:	<input checked="" type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____
		HOME TELEPHONE NUMBER: _____
		DAYTIME TELEPHONE NUMBER: _____
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):	
AGREEMENTS I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.		
I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No		
In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
I agree to review and update this information whenever a change occurs and at least once every six months. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE		
DATE: _____		

315 E. 54th St #1H
NY, NY 10003
LIC# 433483

OCFS-LDSS-0792 (1/2005) REVERSE

Authorized Escorts

As of _____ I _____
(Effective date) (日付) (Parent's name) (親の氏名)

authorize the following individuals to **pick up** my son /
daughter _____ from _____

home. _____
(Child's name) (子供の名前) (Provider's name) (提供者の名前)

私は下記に記載された者が私の息子/娘を
ピックアップする事を承認します。

***I understand that I am responsible for keeping this list
up to date and if there are any **changes** I will **notify** the
provider **in writing** immediately.

下記のリストが最新の物であり車入の責任を理解し、変更がある場合は
直ちに書面にて連絡致します。

Escort #1:

Relationship to child: _____
Name: _____
Address: _____
Telephone: _____

Escort #2:

Relationship to child: _____
Name: _____
Address: _____
Telephone: _____

Escort #3:

Relationship to child: _____
Name: _____
Address: _____
Telephone: _____