

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

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"/> Diabetes _____ <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 _____

ASTHMA In the past 12 months has the child been to the ED or been admitted to the hospital for breathing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the child ever been diagnosed with asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Indicate Severity: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Severe Persistent	In the past 12 months has the child been prescribed any of the following medications for asthma or breathing problems? <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller medication <input type="checkbox"/> B ₂ -agonist <input type="checkbox"/> Oral steroid <input type="checkbox"/> No medication If Yes to any of the above, complete and attach an Asthma Action Plan (AAP) . (Call 311 to order blank AAPs).
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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"/> <input type="checkbox"/> Imitates vocalizing <input type="checkbox"/> <input type="checkbox"/> Turns to voice <input type="checkbox"/> <input type="checkbox"/> Rolls over <input type="checkbox"/> <input type="checkbox"/> Reaches (each hand) <input type="checkbox"/> <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"/> <input type="checkbox"/> Stands alone 2 secs <input type="checkbox"/> <input type="checkbox"/> Bangs two blocks <input type="checkbox"/> <input type="checkbox"/> Says "Mama/Dada" specifically <input type="checkbox"/> <input type="checkbox"/> Responds to "NO" <input type="checkbox"/> <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"/> <input type="checkbox"/> Imitates household chores (sweeping) <input type="checkbox"/> <input type="checkbox"/> Says 4 words besides "Mama/Dada" <input type="checkbox"/> <input type="checkbox"/> Points to one body part "show me your nose" <input type="checkbox"/> <input type="checkbox"/> Drinks from a cup <input type="checkbox"/> <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"/> <input type="checkbox"/> Kicks ball forward <input type="checkbox"/> <input type="checkbox"/> Combines 2 words <input type="checkbox"/> <input type="checkbox"/> Strangers understand half child's speech <input type="checkbox"/> <input type="checkbox"/> Points to 6 named body parts (nose, eyes...) <input type="checkbox"/> <input type="checkbox"/> Names 1 animal picture <input type="checkbox"/> <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"/> <input type="checkbox"/> Can hold 2-3 sentence conversation <input type="checkbox"/> <input type="checkbox"/> Names 4 animal pictures <input type="checkbox"/> <input type="checkbox"/> Knows 2 animal actions: which flies, meows etc. <input type="checkbox"/> <input type="checkbox"/> Understands what to do when tired, cold or hungry (1 out of 3) <input type="checkbox"/> <input type="checkbox"/> Imitates a vertical line <input type="checkbox"/> <input type="checkbox"/> Washes and dries hands <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> AVOIDS INTERACTIVE PLAY </div>	Y N <input type="checkbox"/> <input type="checkbox"/> Knows first and last names <input type="checkbox"/> <input type="checkbox"/> Understands what to do when tired, cold or hungry (2 out of 3) <input type="checkbox"/> <input type="checkbox"/> Plays interactive games (like tag) <input type="checkbox"/> <input type="checkbox"/> Walks up stairs not holding on <input type="checkbox"/> <input type="checkbox"/> Toilet trained/night BY 5 YEARS Y N <input type="checkbox"/> <input type="checkbox"/> Throws a ball overhand <input type="checkbox"/> <input type="checkbox"/> Draws a three-part person <input type="checkbox"/> <input type="checkbox"/> Copies a cross <input type="checkbox"/> <input type="checkbox"/> Names four colors <input type="checkbox"/> <input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, specify: _____ _____ _____
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Child's Name: _____

DOB: ____/____/____

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"/>
Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test. (ages 3-6 yrs)	FAR NEAR Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PF Both <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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 _____

	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)

- _____
- _____
- _____
- _____
- _____

PLAN (Therapies, Referrals, F/U)

- Next Appointment Date ____/____/____
- Follow-up Needed Yes No
(Specify referral and 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 _____