CONFIDENTIAL MEDICAL RECORD

Children's Center of John Jay College of Criminal Justice
445 W 59th Street #1500N
New York, NY 10019

NEW YORK CITY DEPARTMENT OF HEALTH
BUREAU OF DAY CARE
CHILDREN'S MEDICAL RECORD
NEW ADMISSION RECORD

Date of Admission: ____/____/____

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

Birth History
- ❑ Normal
- ❑ High Risk or Problems- Specify _____

_____
_____
_____

Past Medical History
- ❑ Normal
- ❑ High Risk or Problems- Specify _____

_____
_____
_____

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

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)

PERSISTANT
- ❑ 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

❑ ECHOLALIA (repeating what was just said)

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)

Head Circumference (up to 24 mos) _____in _____(%'ile)

Weight _____lbs _____(%'ile)

Blood Pressure (after 3 years of age)_____/_____

Child's Name: _____ DOB _____/_____/_____ **NEW ADMISSION RECORD**

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit **Or** - Hemoglobin		Hct. % - - - - - - - - - - - - Hb gms%
Newborn Screening **or** - Hemoglobin Electrphoresis		
Lead Risk Assesment - Lead Screening (Venous preferred)		
Tuberculin Test (PPD Mantoux)*		
Vision Screening		
Hearing Screening		
Urinalysis (Optional)		
OTHER TESTS *(Specify)* _____		
_____		
_____		

* See recommended schedule: Not required 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; 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 habit? ☐ 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					
Other, Specify:					

DIAGNOSIS/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 _____