

CONFIDENTIAL MEDICAL RECORD

Montessori Day School of Brooklyn
787A Washington Avenue
Brooklyn, NY 11238

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

PERIODIC EXAM/FOLLOW-UP RECORD

TO BE FILLED OUT BY DAY CARE STAFF

(Last)	(First)	(Middle)	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH: ____/____/____ Birth weight: _____ Place of Birth: _____
NAME:				
(No.)	(Street)	(City/Boro)	(State)	(Zip)
ADDRESS:				
REASON FOR REFERRAL TO MEDICAL FACILITY / PHYSICIAN BY DAY CARE CENTER:				
<input type="checkbox"/> Periodic Examination <input type="checkbox"/> Health Problem (Specify) _____ <input type="checkbox"/> Other (Specify) _____				
NAME: Day Care Director/Teacher/Nurse _____			Date of Referral ____/____/____	
TEACHER: Report on professional observations; child's progress/experiences in program (OPTIONAL)				
Signed: _____				

PHYSICIAN'S REPORT TO DAY CARE	
PERTINENT MEDICAL HISTORY SINCE LAST EXAMINATION 	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 Section "Diagnoses/Plan" in 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

PHYSICAL EXAMINATION (Please fill out completely)	
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: _____ _____ _____

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		
Hearing Screening		
Urinalysis (Optional)		
OTHER TESTS (Specify)		

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 _____

* See recommended schedule: Not required for all children.

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 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 _____