

CONFIDENTIAL MEDICAL RECORD

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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

BUREAU OF DAY CARE
CHILDREN'S MEDICAL RECORD

NEW ADMISSION RECORD

Date of Admission: ___ / ___ / ___

| | | | | |
|-----------------|----------|-------------|---|--|
| (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: | | | | |

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: 5px; margin-top: 10px;"> <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: 5px; margin-top: 10px;"> <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: 5px; margin-top: 10px;"> <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: 5px; margin-top: 10px;"> 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: 5px; margin-top: 10px;"> <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: _____ |
|---|--|

Child's Name: _____

DOB ____/____/____

NEW ADMISSION RECORD

318KA-1 (REV. 2/04)

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.

| | DATE IMMUNIZATION GIVEN | | | | |
|--------------|-------------------------|-----|-----|-----|-----|
| | 1st | 2nd | 3rd | 4th | 5th |
| DTP | | | | | |
| DT | | | | | |
| DTaP | | | | | |
| Hib | | | | | |
| OPV/IPV | | | | | |
| Hep B | | | | | |
| MMR | | | | | |
| Varicella | | | | | |
| Pneumococcal | | | | | |

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

- 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 _____

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?

Signature _____ Date of Exam. _____

Name (PLEASE PRINT) _____ Degree: _____

License No. _____ Telephone No. _____

Address _____

Name/Address Stamp, if available: