

CONFIDENTIAL MEDICAL RECORD

BUSY BEACH DAY CARE CENTER, INC.
 777 SEAVIEW AVE., BLDG. #11
 STATEN ISLAND, NEW YORK 10305
 (718) 667-2861
 FAX #: (718) 667-2538

NEW YORK CITY DEPARTMENT OF HEALTH
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 _____
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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 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"/> <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 <input type="checkbox"/> AVOIDS EYE CONTACT	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" <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR <input type="checkbox"/> TUNES OUT	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 <input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> TOE WALKING	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) PERSISTENT <input type="checkbox"/> ROCKING <input type="checkbox"/> HEADBANGING <input type="checkbox"/> HANDFLAPPING	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 <input type="checkbox"/> ECHOLALIA (repeating what was just said)	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

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: _____ _____ _____
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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 or 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 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					
Other, Specify					

DIAGNOSES/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 _____