

**CONFIDENTIAL MEDICAL RECORD**

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

Agency Stamp

**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: _____
<b>NAME:</b>				

(No.)	(Street)	(City/Boro)	(State)	(Zip)
<b>ADDRESS:</b>				

**REASON FOR REFERRAL TO MEDICAL FACILITY / PHYSICIAN BY DAY CARE CENTER:**

Periodic Examination  
 Health Problem (Specify) \_\_\_\_\_  
 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**

<b>PERTINENT MEDICAL HISTORY SINCE LAST EXAMINATION</b>	<b>ALLERGIES:</b> <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
<b>Y N</b> <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>	<b>Y N</b> <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>	<b>Y N</b> <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>	<b>Y N</b> <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>	<b>Y N</b> <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>	<b>Y N</b> <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 <b>BY 5 YEARS</b> <b>Y N</b> <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: _____ _____ _____
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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"/>
Hearing Screening		
OTHER TESTS (Specify)		

\* See recommended schedule: Not required at entry or for all children.

**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 \_\_\_\_\_

**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 \_\_\_\_\_