TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

CENTER						318K (REV. 4/1	
NAME: ADDRESS:	NE	W YORK O	ITY D		NT OF HEALTH A	ND MENTAL HYGIEI	
BORO:		DA	YCAI	RE CUMU	LATIVE HEALT	H RECORD	
Date of Admission//							
(Last) (First	st)	(Middle)		SEX	DATE OF BIRTH Country/State of		
NAME: (No.) (Street)	- AND	(City/Boro)		- M -	(State)	(Zip)	
ADDRESS:						espon to violate	
MOTHER'S NAME: (First) (Last) FATH	HER'S NAME	: (First)		(Last)	TELEPHONE NO Home: Work:	max d listiayo	
FOSTER PARENT					sportiev	Jevel gmental Sun	
FOSTER AGENCY	ADDRES	SS			TELEPHONE #	(bit or dilw) regard	
LANGUAGE SPOKEN IN HOME						Inil 2 Main Conell	
PERSON/S TO CONTAC	CT IN CASE	OF EMERGE	NCY (C	other Than P	arent)		
NAME		RELATION	SHIP T	O CHILD			
ADDRESS					TELEPHONE NO. Home: Work:	isumarkin kispinisi * ********************************	
NAME OF MED	DICAL PROVI	DER, CLINIC	OR H	OSPITAL		basi besid to 1	
NAME	COI	NTACT PERS	ON		Visiting in	PATIENT NO.	
ADDRESS					TELEPHONE NO		
SIGNIFICANT FAMILY HISTORY				IS	CHILD ALLERGIC T	O ANY:	
() Asthma () Heart Dise			(ons (Specify)	60 8126	
() Diabetes () Hypertens () Convulsive Disorder () Tuberculo			(_) Foods (S	Specify)	The state of the s	
() Allergies (Specify) () Vision () OTHER (Specify) () Hearing			(_) Insect B	et Bites		
			VEC			N. A.INI	
HOSPITALIZATIONS AND ILLNESSES Has child ever been hospitalized or operated on?			YES	NO	EXI	PLAIN	
Has child ever had a serious accident (broken bone, head injury, fa	all burns poi	coning)?			XIVORISME	B Screening FPE	
Has child ever had a serious accident (broken bone, nead injury, is Has child ever had a serious illness?	all, burns, pois	soning)?				an an	
SPECIAL HEALTH CONDITIONS (Long term or chronic)	AGE	IT BEGAN			TREATMENT/MEDI	CATIONS	
1.							
2.						81	
3.						G bull of	
5.					- 80	node incommit tedto	
l,	here	eby certify the	nat info	rmation pro	ovided herein is co	mplete and accurate	
CONSENT FOR EMERGENCY MEDICAL TREATMENT (REQUIR	RED FOR ADMI	SSION TO DAY	CARE)	estimate.	Hamiltonia s	noiseimha an	

CONSENT FOR EMERGENCY MEDICAL TREATMENT (REQUIRED FOR ADMISSION TO DAY CARE)

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _______ DATE ______ RELATIONSHIP ______

Subscribed and sworn to before me this ______ day of ______ 19 _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

New York City Department of Health and Mental Hygiene BUREAU OF CHILD CARE

Health Maintenance Checklist

Ages: 2 months - 5 years

PROCEDURES	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	2 yrs.	2 1/2 yrs.	3 yrs.	3 1/2 yrs.	4 yrs.	4 1/2 yrs.	5 yrs.
History or Update										# 1		22.10	000	
Physical Exam			the s	-300	KERE		1306.3				2360	r Children	ion.	
Developmental Surveillance												le ser	Wil.	
Height (with % 'ile)				Accise										
Weight (with % 'ile)														
Blood Pressure	511 713	ON TOPE	GITA I	30 384	OHT		THE PH	URBN.					DAY!	ā
Hematocrit/Hemoglobin			*											
Urine Analysis*														
Direct Blood Lead Venous (Preferred) or Capillary	281199		MALES (9 MAGE	22 10	MAI						Tak F	
Lead Risk Assessment														8
Sickle Cell Electrophoresis**														
Vision Screening Distance	Total State of the last of the										10726			N.
Strabismus	1001				100	teatraq dua vac			103	mod e				
Audio (Hearing) Screening						Series Series				NORGE NORGE	12020 R.B.			200
Dental Assessment		247							>22.3L	I) GHA	ENICATE	a jare	97	
TB Screening-PPD/Mantoux							The line		20 (20)	ich kod	beet to			
DTP									1003	L. 2009				
OPV														
MMR												L III		
HIB														
Hepatitis B														
Other Immunizations														

INSTRUCTIONS:

When Admission Health Form submitted, check off procedures completed to date.

As periodic health maintenance is completed maintain checklist as cumulative record of child's care.

-2-

^{*}Optional determined by risk category

^{**}TEST RESULTS - If given at birth - Medical provider can obtain results by calling 1-800-535-3079

SUMMARY PROGRESS NOTES

DATE	HEALTH PROBLEMS	FINDINGS, TREATMENT, RECOMMENDATIONS AND FOLLOW-UP CONFERENCES	FOLLOW-UP PENDING
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SUMMARY PROGRESS NOTES - Cont'd

DATE	HEALTH PROBLEMS	FINDINGS, TREATMENT, RECOMMENDATION AND FOLLOW-UP CONFERENCES	ONS AME	FOLLOV PENDI	V-UP NG
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AGE IT BEGAN	TREATMENT/MEDICATIONS
	AGE IT BEGAN

HEALTH PROBLEMS

 Physical and behavorial conditions warranting observation by program staff, referral for diagnosis and/or treatment. Enter each referral initiated, report received and follow-up activity.

CHILD CARE HEALTH RECORD

Bureau of Child Care — Department of Health and Mental Hygiene — The City of New York

318K (REV. 4/12) -4-