

Agency Stamp

NEW ADMISSION RECORD

Date of Admission: ___ / ___ / ___

NAME: _____ _____ _____	(Last)	(First)	(Middle)	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH: ___ / ___ / ___ Birth weight: _____ Place of Birth: _____
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: _____ _____ _____
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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)		

* See recommended schedule: Not required 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
- 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 _____	