CONFIDENTIAL MEDICAL RECORD

Agency Stamp

NEW YORK CITY DEPARTMENT OF HEALTH
DAY CARE PROGRAM
CHILDREN'S MEDICAL RECORD

PERIODIC EXAM/FOLLOW-UP RECORD

TO BE FILLED OUT BY DAY CARE STAFF

(Last)	(First)	(Middle)	SEX ☐ F ☐ M	DATE OF BIRTH: ___/___/___
NAME:				Birth weight: _____
				Place of Birth: _____

(No.) (Street) (City/Boro) (State) (Zip)

ADDRESS:

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

PERTINENT MEDICAL HISTORY SINCE LAST EXAMINATION

ALLERGIES: ☐ NONE
- ☐ FOOD _____
- ☐ MEDICINE _____
- ☐ 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 Section 'Diagnoses/Plan' in back of form.*

BY 6 MONTHS

Y	N	
☐	☐	Imitates vocalizing
☐	☐	Turns to voice
☐	☐	Rolls over
☐	☐	Reaches (each hand)
☐	☐	Cuddles

☐ AVOIDS EYE CONTACT

BY 12 MONTHS

Y	N	
☐	☐	Stands alone 2 secs
☐	☐	Bangs two blocks
☐	☐	Says "Mama/Dada" specifically
☐	☐	Responds to "NO"
☐	☐	Plays patty cake or waves "bye-bye"

☐ AVOIDS EYE CONTACT
☐ CONCERN THAT CHILD CAN'T HEAR
☐ TUNES OUT

BY 18 MONTHS

Y	N	
☐	☐	Imitates household chores (sweeping)
☐	☐	Says 4 words besides "Mama/Dada"
☐	☐	Points to one body part "show me your nose"
☐	☐	Drinks from a cup
☐	☐	Scribbles

☐ AVOIDS EYE CONTACT
☐ TOE WALKING

BY 2 YEARS

Y	N	
☐	☐	Kicks ball forward
☐	☐	Combines 2 words
☐	☐	Strangers understand half child's speech
☐	☐	Points to 6 named body parts (nose, eyes...)
☐	☐	Names 1 animal picture
☐	☐	Takes off clothing (other than hat)

PERSISTENT
☐ ROCKING
☐ HEADBANGING
☐ HANDFLAPPING

BY 3 YEARS

Y	N	
☐	☐	Can hold 2-3 sentence conversation
☐	☐	Names 4 animal pictures
☐	☐	Knows 2 animal actions: which flies, meows etc.
☐	☐	Understands what to do when tired, cold or hungry (1 out of 3)
☐	☐	Imitates a vertical line
☐	☐	Washes and dries hands

☐ ECHOLALIA (repeating what was just said)

BY 4 YEARS

Y	N	
☐	☐	Knows first and last names
☐	☐	Understands what to do when tired, cold or hungry (2 out of 3)
☐	☐	Plays interactive games (like tag)
☐	☐	Walks up stairs not holding on
☐	☐	Toilet trained/night

BY 5 YEARS

Y	N	
☐	☐	Throws a ball overhand
☐	☐	Draws a three-part person
☐	☐	Copies a cross
☐	☐	Names four colors
☐	☐	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: ☐ Normal

☐ Abnormal, specify: _____

_____

_____

Child's Name: _____ DOB____/____/____ **PERIODIC EXAM/FOLLOW-UP RECORD**

318KA (REV. 8/01)

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:* ____/____/____

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					
Pneumococcal					

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 _____