

CENTER

318K (REV. 8/02)

NAME:

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

ADDRESS:

BORO:

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

NAME: (Last) (First) (Middle)			SEX F ☐ M ☐	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)				
MOTHER'S NAME: (First) (Last)		FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT				
FOSTER AGENCY		ADDRESS		TELEPHONE #
LANGUAGE SPOKEN IN HOME				

PERSON/S TO CONTACT IN CASE OF EMERGENCY (Other Than Parent)	
NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL		
NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY	IS CHILD ALLERGIC TO ANY:
() Sickle Cell () Heart Disease () Diabetes () Hypertension () Convulsive Disorder () Tuberculosis () Allergies (Specify) () Vision () OTHER (Specify) () Hearing	() Medications (Specify) () None () Foods (Specify) () Insect Bites () OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS	AGE IT BEGAN	TREATMENT/MEDICATIONS
(Long term or chronic)		
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

I, _____ hereby certify that information provided herein is complete and accurate.
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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 _____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF