

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

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"/> Diabetes _____ <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 _____

ASTHMA In the past 12 months has the child been to the ED or been admitted to the hospital for breathing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the child ever been diagnosed with asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Indicate Severity: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Severe Persistent	In the past 12 months has the child been prescribed any of the following medications for asthma or breathing problems? <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller medication <input type="checkbox"/> B ₂ -agonist <input type="checkbox"/> Oral steroid <input type="checkbox"/> No medication If Yes to any of the above, complete and attach an Asthma Action Plan (AAP) . (Call 311 to order blank AAPs).
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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 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: 5px;"> <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: 5px;"> <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: 5px;"> <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: 5px;"> 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: 5px;"> <input type="checkbox"/> AVOIDS INTERACTIVE PLAY </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) Weight _____ lbs BMI _____ (% 'ile) Head Circumference (up to 24 mos) _____ in _____ (% 'ile) Blood Pressure (after 3 years of age) _____ / _____	Physical examination: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, specify: _____ _____ _____
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