CENTER

318K (REV. 8/02)

NAME: Little Blossoms Montessori

ADDRESS: 14-08 Astoria Park South, #1
Astoria, NY 11102

BORO: Queens

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

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

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	(____) Medications (Specify)
(____) Diabetes	(____) Hypertension	(____) None
(____) Convulsive Disorder	(____) Tuberculosis	(____) Foods (Specify)
(____) Allergies (Specify)	(____) Vision	(____) Insect Bites
(____) OTHER (Specify)	(____) Hearing	(____) 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 (Long term or chronic)	AGE IT BEGAN	TREATMENT/MEDICATIONS
1.		
2.		
3.		
4.		
5.		

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

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 DAY 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														
Physical Exam														
Developmental Surveillance														
Height (with % 'ile)														
Weight (with % 'ile)														
Blood Pressure														
Hematocrit/Hemoglobin			*											
Urine Analysis*														
Direct Blood Lead Venous (Preferred) or Capillary														
Lead Risk Assessment														
Sickle Cell Electrophoresis**														
Vision Screening Distance														
Strabismus														
Audio (Hearing) Screening														
Dental Assessment														
TB Screening–PPD/Mantoux														
DTP														
OPV														
MMR														
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.

***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

SUMMARY PROGRESS NOTES – Cont'd

DATE	HEALTH PROBLEMS	FINDINGS, TREATMENT, RECOMMENDATIONS AND FOLLOW-UP CONFERENCES	FOLLOW-UP PENDING

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

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.