CENTER

NAME:

ADDRESS:

BORO: Brooklyn, NY

318K (REV. 8/02)

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

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough	State	Zip Code	School/Center/Camp Name	District Number __ __ __	Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent — Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______________________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______________________

☐ Foods *(list)* ______________________

☐ Other *(list)* ______________________

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______________
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height ____________ **cm** (___ ___ %ile)

Weight ____________ **kg** (___ ___ %ile)

BMI ____________ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _______ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _________ / _________

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? Date Screened

☐ Yes ☐ No ____/____/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______________

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____ /____ /____ ____ /____ /____	________ μg/dL ________ μg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____ /____ /____	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	____ /____ /____	________ g/dL ________ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap		___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___	______	___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______________________ ________

______________________ ________

______________________ ________

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______________________

Follow-up Needed ☐ No ☐ Yes, for ______________ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______________________

Health Care Practitioner Signature	Date Form Completed _____ /_____ /_____
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State
Facility Name	National Provider Identifier (NPI)

Address	City	State	Zip

Telephone	Fax	Email

DOHMH ONLY **PRACTITIONER I.D.** ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: _____ / _____ / _____ **I.D. NUMBER** ☐☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	Date
Signature	Date

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*