

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

| | | |
|--|--|------------|
| CHILD'S NAME | SEX | BIRTH DATE |
| FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? | |
| MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? | |
| IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION | |

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

| | | | | | |
|------------|--------|-------------------|--------|-----------------------------|--------|
| WALKED AT* | MONTHS | BEGAN TALKING AT* | MONTHS | TOILET TRAINING STARTED AT* | MONTHS |
|------------|--------|-------------------|--------|-----------------------------|--------|

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

| | DATES | | DATES | | DATES |
|--|-------|---|-------|--|-------|
| <input type="checkbox"/> Chicken Pox | | <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Poliomyelitis | |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Ten-Day Measles (Rubeola) | |
| <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Whooping cough | | <input type="checkbox"/> Three-Day Measles (Rubella) | |
| <input type="checkbox"/> Hay Fever | | <input type="checkbox"/> Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| | | |
|--|------------------------|---|
| DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO | HOW MANY IN LAST YEAR? | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF |
|--|------------------------|---|

DAILY ROUTINES (*For infants and preschool-age children only)

| | | |
|-----------------------------------|----------------------------------|-------------------------|
| WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?* |
| DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?* |

| | | |
|---|-----------|--|
| DIET PATTERN: (What does child usually eat for these meals?) | BREAKFAST | WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____ |
| | LUNCH | |
| | DINNER | |
| | | |

| | |
|--------------------|----------------------|
| ANY FOOD DISLIKES? | ANY EATING PROBLEMS? |
|--------------------|----------------------|

| | | | |
|--|-------------------------|--|----------------------|
| IS CHILD TOILET TRAINED?* | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* | WHAT IS USUAL TIME?* |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

| | |
|---------------------------------|--------------------------|
| WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION* |
|---------------------------------|--------------------------|

| |
|---------------------------------------|
| PARENT'S EVALUATION OF CHILD'S HEALTH |
|---------------------------------------|

| | | | |
|--|-------------------------|--|---|
| IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

| | | | |
|--|--------------------|--|--------------------|
| DOES CHILD USE ANY SPECIAL DEVICE(S): | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? | IF YES, WHAT KIND: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

| |
|--|
| PARENT'S EVALUATION OF CHILD'S PERSONALITY |
|--|

| |
|--|
| HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN? |
|--|

| |
|---|
| HAS THE CHILD HAD GROUP PLAY EXPERIENCES? |
|---|

| |
|--|
| DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.) |
|--|

| |
|--|
| WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL? |
|--|

| |
|--|
| REASON FOR REQUESTING DAY CARE PLACEMENT |
|--|

| | |
|--------------------|------|
| PARENT'S SIGNATURE | DATE |
|--------------------|------|