TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

318K (REV. 6/95)

**CENTER**
**NAME:**
**ADDRESS:**
**BORO:**

**NEW YORK CITY DEPARTMENT OF HEALTH**
**BUREAU OF DAY CARE**

# 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 | (_____) 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** | **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.

**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