

CENTER
 NAME:
 ADDRESS:
 BORO:
 Date of Admission: / /

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

DAY CARE CUMULATIVE HEALTH RECORD

TO BE COMPLETED BY PARENTS/GUARDIAN AND DAY CARE STAFF

NAME: (Last)	(First)	SEX	DATE OF BIRTH	Country/ State of Birth
ADDRESS:			APT#	STATE/ZIP CODE
MOTHER'S NAME: (Last) (First)		PHONE 1:		
		PHONE 2:		
FATHER'S NAME (Last) (First)		PHONE 1:		
		PHONE 2:		
LANGUAGE SPOKEN IN HOME				

PERSONS TO CONTACT IN CASE OF EMERGENCY (OTHER THAN A PARENT)		
NAME: (Last) (First)	RELATIONSHIP TO CHILD	PHONE 1:
		PHONE 2:
NAME: (Last) (First)	RELATIONSHIP TO CHILD	PHONE 1:
		PHONE 2:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL		
NAME:	CONTACT PERSON	PHONE:
ADDRESS:		

SIGNIFICANT FAMILY HISTORY	IS THE CHILD ALLERGIC TO ANY:
<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Medications (Specify) _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> None
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Foods (Specify) _____
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Insect Bites _____
<input type="checkbox"/> Convulsive Disorder	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> Allergies (Specify) _____	<input type="checkbox"/> Vision
<input type="checkbox"/> OTHER (Specify) _____	<input type="checkbox"/> Hearing
	<input type="checkbox"/> OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has the 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 AND MEDICATIONS
1.		
2.		
3.		

➔ I, _____ here by 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 _____ REALTIONSHIP _____
 Subscribed and sworn to before me this _____ day of _____ 20_____

Notary Public or Commissioner of Deeds (OPTIONAL) _____ County of _____