

NAME:

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

ADDRESS:

BORO:

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission \_\_\_\_ / \_\_\_\_ / \_\_\_\_

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME:	(Last)	(First)	(Middle)	SEX F <input type="checkbox"/> M <input type="checkbox"/>	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					

PERSONS 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 ( ) Diabetes                        ( ) Hypertension ( ) Convulsive Disorder        ( ) Tuberculosis ( ) Allergies (Specify)         ( ) Vision ( ) OTHER (Specify)            ( ) Hearing	( ) Medications (Specify) _____ ( ) None _____ ( ) Foods (Specify) _____ ( ) Insect Bites _____ ( ) 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 _____