TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

318K (REV. 8/02)

CENTER
NAME:
ADDRESS:
BORO:

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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