

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

ILLNESS	DATES	ILLNESS	DATES	ILLNESS	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 (Rubella)	
<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? YES 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?*
<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____

DIET PATTERN: (What does child usually eat for these meals?)

DIET PATTERN	BREAKFAST	LUNCH	DINNER	WHAT ARE USUAL EATING HOURS?
	_____	_____	_____	BREAKFAST _____ LUNCH _____ DINNER _____

ANY FOOD DISLIKES? _____

ANY EATING PROBLEMS? _____

IS CHILD TOILET TRAINED?*

<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
	_____	<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 DEVICES?	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICES 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 _____