CENTER

NAME:

ADDRESS:

BORO:

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

DAY CARE CUMULATIVE HEALTH RECORD

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

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