

**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

|  |   |            |
|--|---|------------|
| CHILD'S NAME   | SEX                                       | BIRTH DATE |
| FATHER'S NAME  | DOES FATHER LIVE IN HOME WITH CHILD?      |            |
| MOTHER'S NAME  | DOES MOTHER 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* | BEGAN TALKING AT* | TOILET TRAINING STARTED AT* |
| MONTHS     | MONTHS            | MONTHS                      |

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

|  | DATES |   | DATES |  | 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 (Rubeola)   |       |
| <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? <input type="checkbox"/> YES <input type="checkbox"/> 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?*   |
| DIET PATTERN:<br>(What does child usually eat for these meals?) | BREAKFAST<br>LUNCH<br>DINNER     | WHAT ARE USUAL EATING HOURS?<br>BREAKFAST _____<br>LUNCH _____<br>DINNER _____ |

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| ANY FOOD DISLIKES? | ANY EATING PROBLEMS? |
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|--|-------------------------|--|----------------------|
| IS CHILD TOILET TRAINED?*                                | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?*                            | WHAT IS USUAL TIME?* |
| <input type="checkbox"/> YES <input type="checkbox"/> NO |                         | <input type="checkbox"/> YES <input type="checkbox"/> NO |                      |

|                                 |                          |
|---------------------------------|--------------------------|
| WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION* |
|---------------------------------|--------------------------|

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| PARENT'S EVALUATION OF CHILD'S HEALTH |
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|--|-------------------------|--|---|
| 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 DEVICE(S):                    | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?            | IF YES, WHAT KIND: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO |                    | <input type="checkbox"/> YES <input type="checkbox"/> NO |                    |

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| PARENT'S EVALUATION OF CHILD'S PERSONALITY |
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| HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN? |
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| HAS THE CHILD HAD GROUP PLAY EXPERIENCES? |
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| DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.) |
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| WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL? |
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| REASON FOR REQUESTING DAY CARE PLACEMENT |
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| PARENT'S SIGNATURE | DATE |
|--------------------|------|