

### 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 THIS CHILD BEING 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 |
|--|-------|--|-------|
| <input type="checkbox"/> Chicken Pox     |       | <input type="checkbox"/> Diabetes                    |       |
| <input type="checkbox"/> Asthma          |       | <input type="checkbox"/> Epilepsy                    |       |
| <input type="checkbox"/> Rheumatic Fever |       | <input type="checkbox"/> Whooping cough              |       |
| <input type="checkbox"/> Hay Fever       |       | <input type="checkbox"/> Mumps                       |       |
|  |       | <input type="checkbox"/> Poliomyelitis               |       |
|  |       | <input type="checkbox"/> Ten-Day Measles (Rubella)   |       |
|  |       | <input type="checkbox"/> Three-Day Measles (Rubella) |       |

SPECIFY ANY OTHER SERIOUS OR RECURRENT 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?*  |
|   |                                  | HOW LONG?*   |
| DOES CHILD SLEEP DURING THE DAY?*                               | WHEN?*                           |  |
| DIET PATTERN:<br>(WHAT DOES CHILD USUALLY eat for these meals?) | BREAKFAST                        | WHAT ARE USUAL EATING HOURS?<br>BREAKFAST _____<br>LUNCH _____<br>DINNER _____ |
|   | LUNCH                            |  |
|   | DINNER                           |  |
|   |                                  |  |

ANY FOOD OBSTACLES?  YES  NO

ANY EATING PROBLEMS?  YES  NO

|  |                         |  |                      |
|--|-------------------------|--|----------------------|
| 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"*                               |                      |

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 DEVICES?                      | 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 |   |

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 EXAMINED BY (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 |
|--------------------|------|