

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
<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 (Rubeola)	
		<input type="checkbox"/> Three-Day Measles (Rubella)	

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?*	
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?	
	LUNCH		BREAKFAST _____
	DINNER		LUNCH _____
			DINNER _____

ANY FOOD DISLIKES? _____ ANY EATING PROBLEMS? _____

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

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	

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 _____