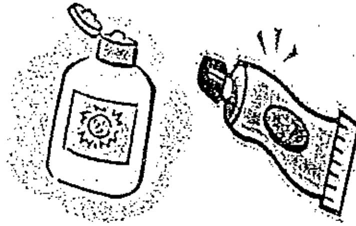
Over The Counter Topical Ointments

PROVIDER: ______________________

GFDC: ______________



Child Name: ______________________ D.O.B: ______________

I ______________________, give ______________________
(Parent Name) (Name of Provider)

permission to apply the following:

☐ diaper rash ____________________ to be applied ___ times a day **OR** ☐ as needed
(Name of ointment)

☐ sunscreen ____________________ to be applied ___ times a day **OR** ☐ as needed
(Name of lotion / cream / spray)

☐ insect repellent ____________________ to be applied ___ times a day **OR** ☐ as needed
(Name of repellent)

☐ I will supply the products ☐ Provider will supply the products

Additional Information:

____

____

____

Signature ______________________ Date ______________
(Parent's signature)

Reminder:

This program does not administer prescribed ointments / creams or medications.

GFDC: ____________________

Feeding Schedule

For: ______________________________ DOB: ____________________
(Child's Name)

I ____,
(Parents Name)

☐ Will supply ______________________, with _____ bottles of prepared
(Name of Provider)

____________________ Formula, to be fed ___ times a day.
(Name of formula)

☐ Give permission to the On-Site Provider to prepare ____________________ Formula
(Name of formula)

for ____ Bottles per day, to be fed ___ times a day.

☐ Will also provide:

___ Bottle/s of water, to be fed ___ times a day,
___ Bottle/s of juice, to be fed ___ times a day,
___ Yogurt, to be fed ___ times a day,
___ Puree fruit, to be fed ___ times a day,
___ Cereal, to be fed ___ times a day by spoon.

Additional Note:

____
____
____
____
____
____

Signature: ____________________ Date: ____________________
(Parents signature)

SLEEPING AND NAPPING ARRANGEMENT

I understand that my child ____________________________ while

under the care of ____________________________________ will be
(Name program provider)

napping on a _______________________ in ___________________
(cot, mat, bed or crib) (Area of the home)

of the provider's home. He or she will be supervised. If my child is an infant, I also understand that my child will be placed on his/her back to sleep

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child,

____
(Name of Child)

with the understanding that the family will be notified as soon as possible.

PERMISSION FOR OUTDOOR ACTIVITIES

The provider _______________________ and staff may take my child

____________________________________ for short walking trips and any
(Name of Child)

other activities checked below as part of the Day Care program activities.

___Provider's backyard ___Neighborhood park _____Other

____
Name Parent/Guardian

_______________________ _________________
Signature Date

FIRE DRILL LOG

Provider: ____________

Provider Program Name: ____________

Address of Program: ____________

GFDC: ____________

IT IS RECOMMENDED THAT YOU ALTERNATE EXITS AND VARY THE TIMES AND DAY WITH EACH DRILL

Date Circle days	Time Start	Time End	Number of Children	Name of Persons Conduction the Drill Conducting	Exit Route Followed P=Primary S=Secondary O=Other (Please Specify) P	S	O	Comments (Include any special notes)
__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								
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__/__/__ S/M/T/W/TH/F/S								
__/__/__ S/M/T/W/TH/F/S								

VISITORS LOG

DATE	NAME	REASON FOR VISIT	TIME IN	TIME OUT	SIGNATURE

VISITORS LOG

DATE	NAME	REASON FOR VISIT	TIME IN	TIME OUT	SIGNATURE

CONFIDENTIAL MEDICAL RECORD

Agency Stamp

NEW YORK CITY DEPARTMENT OF HEALTH
BUREAU OF DAY CARE
CHILDREN'S MEDICAL RECORD

NEW ADMISSION RECORD

Date of Admission: ____ / ____ / ____

(Last) (First) (Middle)	SEX	
NAME:	❑ F ❑ M	DATE OF BIRTH: ___ / ___ / ___ Birth weight: ______ Place of Birth: ______

(No.)	(Street)	(City/Boro)	(State)	(Zip)
ADDRESS:				

PHYSICIAN'S REPORT TO DAY CARE

Significant Family Medical/Social History
Explain Those Marked

❑ Vision ______
❑ Hearing ______
❑ TB ______
❑ Chronic Illnesses ______
❑ Social Concerns ______
❑ Exposure to Violence ______
❑ Other ______

Birth History ❑ Normal
❑ High Risk or Problems– Specify ______

Past Medical History ❑ Normal
❑ High Risk or Problems– Specify ______

ALLERGIES: ❑ NONE
❑ FOOD ______
❑ MEDICINE ______
❑ OTHER ______

DEVELOPMENTAL OBSERVATION *Check "Yes" or "No" for appropriate ages. If more than 2 "No's" or any boxed item is marked in child's age category, indicate follow-up or action taken in the Sections 'Diagnoses, Problems and Plan' on back of form.*

BY 6 MONTHS
Y N
❑ ❑ Imitates vocalizing
❑ ❑ Turns to voice
❑ ❑ Rolls over
❑ ❑ Reaches (each hand)
❑ ❑ Cuddles

❑ AVOIDS EYE CONTACT

BY 12 MONTHS
Y N
❑ ❑ Stands alone 2 secs
❑ ❑ Bangs two blocks
❑ ❑ Says "Mama/Dada" specifically
❑ ❑ Responds to "NO"
❑ ❑ Plays patty cake or waves "bye-bye"

❑ AVOIDS EYE CONTACT
❑ CONCERN THAT CHILD CAN'T HEAR.
❑ TUNES OUT

BY 18 MONTHS
Y N
❑ ❑ Imitates household chores (sweeping)
❑ ❑ Says 4 words besides "Mama/Dada"
❑ ❑ Points to one body part "show me your nose"
❑ ❑ Drinks from a cup
❑ ❑ Scribbles

❑ AVOIDS EYE CONTACT
❑ TOE WALKING

BY 2 YEARS
Y N
❑ ❑ Kicks ball forward
❑ ❑ Combines 2 words
❑ ❑ Strangers understand half child's speech
❑ ❑ Points to 6 named body parts (nose, eyes...)
❑ ❑ Names 1 animal picture
❑ ❑ Takes off clothing (other than hat)

PERSISTENT
❑ ROCKING
❑ HEADBANGING
❑ HANDFLAPPING

BY 3 YEARS
Y N
❑ ❑ Can hold 2-3 sentence conversation
❑ ❑ Names 4 animal pictures
❑ ❑ Knows 2 animal actions: which flies, meows etc.
❑ ❑ Understands what to do when tired, cold or hungry (1 out of 3)
❑ ❑ Imitates a vertical line
❑ ❑ Washes and dries hands

❑ ECHOLALIA (repeating what was just said)

BY 4 YEARS
Y N
❑ ❑ Knows first and last names
❑ ❑ Understands what to do when tired, cold or hungry (2 out of 3)
❑ ❑ Plays interactive games (like tag)
❑ ❑ Walks up stairs not holding on
❑ ❑ Toilet trained/night

BY 5 YEARS
Y N
❑ ❑ Throws a ball overhand
❑ ❑ Draws a three-part person
❑ ❑ Copies a cross
❑ ❑ Names four colors
❑ ❑ Dresses without supervision

COMPLETE PHYSICAL EXAMINATION

Height ______ in ______ (% 'ile)
Head Circumference (up to 24 mos) ______ in ______ (% 'ile)
Weight ______ lbs ______ (% 'ile)
Blood Pressure (after 3 years of age) ______ / ______

Physical examination: ❑ Normal
❑ Abnormal, specify: ______

Child's Name: ______________________ DOB____/____/____

NEW ADMISSION RECORD

318KA-1 (REV. 8/97)

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit		Hct. %
or		
Hemoglobin		Hb gms %
Newborn Screening		
or		
Hemoglobin Electrophoresis		
Lead Risk Assessment		
Lead Screening (Venous preferred)		
Tuberculin Test (PPD Mantoux)*		
Vision Screening		
Hearing Screening		
Urinalysis (Optional)		
OTHER TESTS *(Specify)*		

* See recommended schedule: Not required for all children.

DENTAL ASSESSMENT

Date: _____/____/_____

1. Examiner ❑ MD ❑ DDS ❑ Dental Hygienist ❑ Other Health Care Professional *(Specify)* ________
2. Does the child sleep with a bottle? ❑ Yes ❑ No
3. Findings
   - A. No Visible Problems ....❑ *(Clean mouth, no visible cavities, healthy gums)*
   - B. Some Problems Detected ....❑ *(Cavities, inflamed gums, open bite, malocclusion)*
   - C Severe Problems ....❑ *(Baby bottle tooth decay; extensive cavities; abscesses)*
   - D. Other *(Specify)*: ....❑

   Referral Suggested if B, C or D is checked
4. Has the child been referred to Dentist? ❑ Yes ❑ No

NUTRITIONAL UPDATE

Up to age 1 year: Is the child on?

Formula? ❑ No ❑ Yes

Breast milk? ❑ No ❑ Yes

Solid foods? ❑ No ❑ Yes

1 year and above:

Is child bottle fed? ❑ No ❑ Yes

Type of diet? ________

Unusual dietary habits? ❑ No ❑ Yes, specify ________

Dietary restrictions? ❑ No ❑ Yes, specify ________

IMMUNIZATION HISTORY

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
DTP					
DT					
DTaP					
Hib					▓
OPV/IPV					
Hep B				▓	▓
MMR			▓	▓	▓
Varicella		▓	▓	▓	▓
Other, Specify:					

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS

(Include all chronic conditions or conditions/findings needing follow-up)

1. ________
2. ________
3. ________
4. ________
5. ________

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____
2. Follow-up Needed ❑ Yes ❑ No
   (Specify referral and date) ________
3. ________
4. ________
5. ________

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes ❑ No ❑
2. Special recommendations for child? Specify treatments provided, or recommended evaluations. Does child require special education or early intervention? ________

Name/Address Stamp, if available:

Signature ________ Date of Exam. ________

Name (PLEASE PRINT) ________ Degree: ________

License No. ________ Telephone No. ________

Address ________