COLUMBIA GROUP FAMILY DAYCARE OVER THE COUNTER TOPICAL OINTMENTS



PROVIDER:							
Child Name:		D.O.B.:					
I	(Parent Name, printed)	_, give (Provider Name)					
Permi	ssion to apply the following :						
0	Diaper rash(Name of ointment)	_ to be applied times a day OR as needed					
0	Sunscreen(Name of lotion/cream/spray)	_ to be applied times a day OR as needed					
0	Insect repellent(Name of repellent)	_ to be applied times a day OR as needed					
Additi	onal information:						
Signat	ure: (Parent's signature)	Date:					

Reminder:

This program does not administer prescribed ointments/creams or medications

COLUMBIA GROUP FAMILY DAYCARE FEEDING SCHEDULE





For:		D.O.B.:
(Child's Name)		
I	J	
(Parent's Name, printed)		
Will supply	_ with	_ bottles of prepared
(Provider Name) formula to be fed _	times a	day
(Name of formula)	times a	ady.
Give permission to on-site provider to prep	oare	
_		(Name of formula)
Forbottles per day, to be fed	_ times a day.	
Will also provide:		
Bottles of water, to be fed times	s a day	
Bottles of juice, to be fed time.	s a day	
Yogurt, to be fed times a day		
Puree fruit, to be fed times a	day	
Cereal, to be fed times a da	ау	
Additional Notes:		
Signature:		Date:
(Parent's signature)		

COLUMBIA GROUP FAMILY DAYCARE

SLEEPING AND NAPPING ARANGEMENT

I understand that my child	while under the care of
(Name	of child)
will be na	pping on a in (cot/mat/bed or crib) (Area of the home)
(Name of provider)	(cot/mat/bed or crib) (Area of the home)
of the provider's home. He or she wil that my child will be placed on his/he	l be supervised. If my child is an infant, I also understand r 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,	with the understanding
(Nar that the family will be notified as soo	ne of child) n as possible.
PERMISSI	ON FOR OUTDOOR ACTIVITIES
The providera	nd staff may take my child(Name of child)
(Name of provider)	(Name of child)
for short walking trips and any other activities:	activities checked below as part of the daycare program
Provider's backyard Neighborhood Park Other	
(Name of parent/guardian, printed)	
(Signature of parent/guardian)	(Date)

CHILD & ADOLESCENT HE NYC DEPARTMENT OF HEALTH & MENTAL HYGIEN			FOR	M Pleas Print Clear Press Hai	ly SIL	IDENT ID NI	UMBER OSIS				
TO BE COMPLETED BY PARENT								-			
Child's Last Name	First Name		Middle Name				Sex □ Female Date of Birth (Month/Day/Year) □ Male ///				
Child's Address			Hispanic/Latino? Race (Check ALL that apply) American Indian Asian Black V See No Native Hawaiian/Pacific Islander Other								
City/Borough :	State Zip Code	School/Center/0	Camp Nan	ne			District Number		Numbers		
Health insurance ☐ Yes ☐ Parent/Guardian Last N	Name			First Name							
(including Medicaid)? No Foster Parent								Work _			
TO BE COMPLETED BY HEALTH	CARE PROVIDER	If "yes"	to an	y item, ple	ase ex	plain (at	ttach a	addendum,	if need	ed)	
Birth history (age 0-6 yrs)	Does the child/adolesco	•	-	-		-	t 🗆 Mod	erate Persistent 🗆	Severe Pers	istent	
Uncomplicated □ Premature:weeks gestation □ Making (check severity and attach MAF/Asthma Action Plan): □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severing for persistent, check all current medication(s): □ Inhaled corticosteriod □ Other controller □ Quick relief med □ Oral steroid □											
Complicated by					Orthopedic injury/disability Seizure disorder			Medications (attach MAF if in-school medication needed)			
Allergies None Epi pen prescribed		☐ Chronic or recurrent otitis media☐ Congenital or acquired heart disorder			visual imp	airment	☐ None ☐ Yes (list below)				
☐ Drugs (list)		☐ Developmental/learning problem			infection or a	lisease)					
☐ Foods (list)	— Diabetes (attach MAF)	☐ Diabetes (attach MAF)				I	Dietary Restrictions				
Other (list)	_	Explain all ched	cked iten	ıs above or on add	dendum		☐ Non	e	elow)		
PHYSICAL EXAMINATION	General Appe	arance:									
Height cm (_	%ile)	NI Abni		NI Abni		NI Abnl		NI Abni			
Weight kg (_	— — %ile) 🗆 🗆 HEE	,	mph node ings		omen itourinary		kin eurologica	│		ment	
BMIkg/m² (_	%ile)		Ü		emities	1	ack/spine	Behav	-		
Head Circumference (age ≤2 yrs) cm (_	_{%ile)} Describe abn	ormalities:									
Blood Pressure (age ≥3 yrs) /	_										
DEVELOPMENTAL (age 0-6 yrs)	SCREENING TESTS	Date D	one	Results				Date Done	Resu	lts	
If delay suspected, specify below	Blood Lead Level (BLL)	/	/	µg/	dL Tuber	culosis Or	nly required fo	or students entering inter previously attended any N	mediate/middle/j	unior or high school	
Cognitive (e.g., play skills)	(required at age 1 yr and 2 yrs and for those at risk)	/		μg/	'dl			reviously attended any N			
	Lead Risk Assessment		·		PPD/N	Mantoux <i>place</i>		//	Induration		
☐ Communication/Language	(annually, age 6 mo-6 yrs)	/	/	☐ At risk (do BLL	L) PPD/N	PPD/Mantoux read		//	☐ Neg	☐ Pos	
	Hearing				Interfe	Interferon Test		//	☐ Neg	☐ Pos	
☐ Social/Emotional	☐ Pure tone audiometry☐ OAE	/	/	☐ Normal ☐ Abnormal		Chest x-ray			□ NI	□ Not	
☐ Adaptive/Self-Help	_	│ ├── Head Start	Only —	<u>.</u>	_ `	(if PPD or Interferon positive)		//	☐ Abnl	Indicated	
☐ Motor	Hemoglobin or			g/dL		Vision (required for new school entrants			1	nt /	
	Hematocrit (age 9–12 mo)	/	/	%		idren age 4–7 yrs		// ☐ with glasses	Strabismus	rt / s □ No □ Yes	
IMMUNIZATIONS – DATES CIR Number of Child			Influ	enza		1 1		1 1		1	
Hep B//	//	//	MM		_				/		
Rotavirus//	/	//	Vari	cella		11		11			
DTP/DTaP/DT/	//	//	Td		_	_//_		//	/	_/	
	//	//	Tda	0//_		H	ep A _	//	/	/	
Hib//////	//	//		ingococcal	_	_//_		//			
PCV///////	//	//	HPV		_	//			/		
Polio//////	/	//_	_	er, Specify:		_//_	; _		/	_/	
RECOMMENDATIONS ☐ Full physical activity ☐ Full	diet		ASSI	SSMENT W	ell Child (\	/20.2) 🗌 I	Diagnoses	s/Problems (list)	ı	ICD-9 Code	
☐ Restrictions (specify)			-								
Follow-up Needed		//	-								
Referral(s): ☐ None ☐ Early Intervention ☐ Spec	ial Education Dental	☐ Vision									
Other			_				DD.	OUIDED			
Health Care Provider Signature				Date /	/		HMH PR	OVIDER I.D.			
Health Care Provider Name and Degree (print)		Provider License No. and State					TYPE OF EXAM: NAE Current NAE Prior Year(s)				
Facility Name		National Pr		vider Identifier (NPI)			- Comments				
Address	City			State Zip	p	Date			I.D. NI	UMBER	
							Reviewed://				
Telephone ()	Fax ()				REV	IEWER:				