

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 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	LUNCH	DINNER	WHAT ARE USUAL EATING HOURS?
_____	_____	_____	BREAKFAST _____
_____	_____	_____	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? _____

YES NO YES NO YES 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 _____

YES NO YES NO YES 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 _____

YES NO YES NO YES 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