

CHILD’S PREADMISSION HEALTH HISTORY– PARENT’S REPORT

CHILD’S NAME _____ SEX _____ BIRTHDATE _____

FATHER’S NAME _____ DOES FATHER LIVE IN HOME WITH CHILD? YES NO

MOTHER’S NAME _____ DOES MOTHER LIVE IN HOME WITH CHILD? YES NO

IS/HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? YES NO DATE OF LAST PHYSICAL/MEDICAL EXAMINATION _____

DEVELOPMENTAL HISTORY (* FOR INFANTS AND PRESCHOOL AGE CHILDREN ONLY)

WALKED AT* _____ MONTHS BEGAN TALKING AT* _____ MONTHS TOILET TRAINING STARTED AT* _____ MONTHS

PAST ILLNESSES – Check illnesses that the 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 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?* YES NO

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?* YES NO IF YES, AT WHAT STAGE?* _____ ARE BOWEL MOVEMENTS REGULAR?* YES NO

WORD USED FOR BOWEL MOVEMENTS?* _____ WHAT IS USUAL TIME?* _____ WORD USED FOR URINATION?* _____

PARENT’S EVALUATION OF CHILD’S HEALTH? _____

IS CHILD PRESENTLY UNDER A DOCTOR’S CARE? YES NO IF YES, NAME OF DOCTOR _____ DOES CHILD TAKE PRESCRIBED MEDICATION(S)? YES NO
 IF YES, WHAT KIND AND ANY SIDE EFFECTS: _____

DOES CHILD USE ANY SPECIAL DEVICE(S): YES NO IF YES, WHAT KIND: _____ DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? YES NO
 IF YES, WHAT KIND? _____

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 (PLEASE EXPLAIN) _____

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL? _____

REASON FOR REQUESTING DAY CARE PLACEMENT _____

PARENT’S SIGNATURE _____

DATE _____