

**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/DOMESTIC PARTNER'S NAME	DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/DOMESTIC PARTNER'S NAME	DOES MOTHER/DOMESTIC PARTNER 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 ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**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?
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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*
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PARENT'S EVALUATION OF CHILD'S HEALTH
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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
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HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?
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HAS THE CHILD HAD GROUP PLAY EXPERIENCES?
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DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)
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WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?
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REASON FOR REQUESTING DAY CARE PLACEMENT
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PARENT'S/DOMESTIC PARTNER'S SIGNATURE	DATE
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