GLEN COVE CHILD DAY CARE/HEAD START

Health history to be completed by parent/guardian/ ***Historial médico necesita ser completado por los padres/guardianes***

Child's Name/*Nombre de niño*/a_____
Date of birth/*Fecha denacimiento*: _____ Age /*Edad*_____ Gender/*Sexo*_____
Has your child ever had any of the following? /*A tenido su niño/a algunos de los siguientes?*
Chickenpox/*Varicela*_____Pneumonia/*Pulmonia*_____Asthma/*Asma*_____Diabetes/*Diabetes*_____
Congenital defect /*Defectos congenitales*_____
Seizure disorder/*Desorde de epilepsia*_____ Surgery in past/*Sirugia en el pasado*_____
Other medical problems/*Otros problemas medicos* _____
Is daily Medication taken/ Esta tomando Medicamento? No_____Yes____What Medication / *Que tipo?*_____
Si su hijo/a viaja fuera del país por dos semanas antes de regresar a la escuela se requiere una nota del doctor comunicando que está libre de enfermedades trasmitidas.

This section to be completed by licensed Physician or Nurse Practitioner
ALLERGY: Environmental_____Medications_____Foods_____

Illnesses	Specific details	Most recent occurrence
		_____/_____/_____

Date
____/____/____ Height _____ Weight _____ Blood pressure _____BMI_____#_____%
____/____/____ Blood count HCT _____ HGB _____ Urinalysis _____
____/____/____ Lead level_____[done once between 12 months and 24 months]
___/___/_____ Hearing screening results _____
___/___/_____ Vision screening results _____

Eyes _____ Ears _____
Nose _____ Throat _____
Tonsils _____ Dental_____
Dental _____ Skin_____
Heart_____ Lungs_____
Neuro _____ Genitourinary_____
Hernia _____Scoliosis_____
Ortho _____Extremities_____
Feet _____Other_____

Flu Shot _____

Immunization Record:

	DTaP#1 _____	Polio#1 _____
	DTaP #2 _____	Polio#2 _____
	DTaP #3 _____	Polio#3 _____
	DTaP #4 _____	Polio#4 _____
	DTaP#5_____	Hep A_____
	MMR#1 _____	HepB#1 _____
	MMR#2 _____	HepB#2 _____
	Hib#1 _____	HepB#3 _____
	Hib#2 _____	Prevnar#1_____
	Hib#3 _____	Prevnar#2_____
	Varicella#1_____	Prevnar#3_____
	Varicella #2_____	Prevnar#4_____

Are there any problems relating to the Growth, Development [Cognition, OT, PT, Speech], Behavior or the Nutrition of this child that the nurse/teachers should be made aware of ?_____
_____
Are Multivitamins with Fluoride being prescribed? Yes_____ No_____ If no, please give reason why _____
_____
Does the school need to know anything else about this child? _____
On the basis of my findings and on my knowledge of the above named child, I find that he/she is free from Communicable disease Yes _____No_____.
Is this child able to participate in day care? Yes _____ No_____.
Recommendations: _____

MD Signature _____ Title _____ Date _____

Address _____ Phone number_____

***Please Note*should the child leave the Country for 2 weeks, before returning to school a note is required from the Doctor stating the child is free from Communicable disease.**