Glen Cove Child Day Care Center Inc.

1 Carney Street Ext. PO Box 191 Glen Cove, NY 11542
Phone: (516) 671-2880 Fax: (516) 671-7401

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** ______________________________

Immunization Record:

				DTaP#1	________	**Polio#1**	________
Eyes	________	**Ears**	________	**DTaP #2**	________	**Polio#2**	________
Nose	________	**Throat**	________	**DTaP #3**	________	**Polio#3**	________
Tonsils	________	**Dental**	________	**DTaP #4**	________	**Polio#4**	________
Dental	________	**Skin**	________	**DTaP#5**	________	**Hep A**	________
Heart	________	**Lungs**	________	**MMR#1**	________	**HepB#1**	________
Neuro	________	**Genitourinary**	________	**MMR#2**	________	**HepB#2**	________
Hernia	________	**Scoliosis**	________	**Hib#1**	________	**HepB#3**	________
Ortho	________	**Extremities**	________	**Hib#2**	________	**Prevnar#1**	________
Feet	________	**Other**	________	**Hib#3**	________	**Prevnar#2**	________
				Varicella#1	________	**Prevnar#3**	________
Flu Shot	________			**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.**