CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S 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
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ 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?*~~

~~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?*~~ ~~☐ YES ☐ NO~~ | ~~IF YES, AT WHAT STAGE:*~~ | ~~ARE BOWEL MOVEMENTS REGULAR?*~~ ~~☐ YES ☐ NO~~ | ~~WHAT IS USUAL TIME?*~~

~~WORD USED FOR "BOWEL MOVEMENT"*~~ | ~~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? (EXPLAIN.)

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

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE | DATE