

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

|  |                                      |   |
|--|--------------------------------------|---|
| CHILD'S NAME   | SEX                                  | BIRTH DATE                                |
| FATHER'S NAME  | DOES FATHER LIVE IN HOME WITH CHILD? |   |
| MOTHER'S NAME  | DOES MOTHER 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?  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 | WHAT ARE USUAL EATING HOURS? |
| LUNCH     | BREAKFAST _____              |
| DINNER    | LUNCH _____                  |
|           | DINNER _____                 |

ANY FOOD DISLIKES? \_\_\_\_\_    ANY EATING PROBLEMS? \_\_\_\_\_

|  |                         |  |                      |
|--|-------------------------|--|----------------------|
| 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*                                 |                      |

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 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_