

Agency Stamp

PERIODIC EXAM/FOLLOW-UP RECORD

TO BE FILLED OUT BY DAY CARE STAFF

(Last)	(First)	(Middle)	SEX	DATE OF BIRTH: ____ / ____ / ____
NAME:			<input type="checkbox"/> F	Birth weight: _____
			<input type="checkbox"/> M	Place of Birth: _____

ADDRESS: (No.) _____ (Street) _____ (City/Boro) _____ (State) _____ (Zip) _____

REASON FOR REFERRAL TO MEDICAL FACILITY / PHYSICIAN BY DAY CARE CENTER:

- Periodic Examination
- Health Problem (Specify) _____
- Other (Specify) _____

NAME: Day Care Director/Teacher/Nurse _____ **Date of Referral** ____ / ____ / ____

TEACHER: Report on professional observations; child's progress/experiences in program (OPTIONAL) Signed: _____

PHYSICIAN'S REPORT TO DAY CARE

PERTINENT MEDICAL HISTORY SINCE LAST EXAMINATION	ALLERGIES: <input type="checkbox"/> NONE
	<input type="checkbox"/> FOOD _____
	<input type="checkbox"/> MEDICINE _____
	<input type="checkbox"/> OTHER _____

ASTHMA

In the past 12 months has the child been to the ED or been admitted to the hospital for breathing problems?
 Yes No

Has the child ever been diagnosed with asthma?
 Yes No

If Yes, Indicate Severity:
 Mild Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

In the past 12 months has the child been prescribed any of the following medications for asthma or breathing problems?
 Inhaled corticosteroid Other controller medication
 B₂-agonist Oral steroid No medication

If Yes to any of the above, complete and attach an **Asthma Action Plan (AAP)**.
 (Call 311 to order blank AAPs).

DEVELOPMENTAL OBSERVATION Check "Yes" or "No" for appropriate ages. If more than 2 "No's" or any boxed item is marked in child's age category, indicate follow-up or action taken in the Sections 'Diagnoses, Problems and Plan' on back of form.

BY 6 MONTHS	BY 12 MONTHS	BY 18 MONTHS	BY 2 YEARS	BY 3 YEARS	BY 4 YEARS
Y N	Y N	Y N	Y N	Y N	Y N
<input type="checkbox"/> Imitates vocalizing	<input type="checkbox"/> Stands alone 2 secs	<input type="checkbox"/> Imitates household chores (sweeping)	<input type="checkbox"/> Kicks ball forward	<input type="checkbox"/> Can hold 2-3 sentence conversation	<input type="checkbox"/> Knows first and last names
<input type="checkbox"/> Turns to voice	<input type="checkbox"/> Bangs two blocks	<input type="checkbox"/> Says 4 words besides "Mama/Dada"	<input type="checkbox"/> Combines 2 words	<input type="checkbox"/> Names 4 animal pictures	<input type="checkbox"/> Understands what to do when tired, cold or hungry (2 out of 3)
<input type="checkbox"/> Rolls over	<input type="checkbox"/> Says "Mama/Dada" specifically	<input type="checkbox"/> Points to one body part "show me your nose"	<input type="checkbox"/> Strangers understand half child's speech	<input type="checkbox"/> Knows 2 animal actions: which flies, meows etc.	<input type="checkbox"/> Plays interactive games (like tag)
<input type="checkbox"/> Reaches (each hand)	<input type="checkbox"/> Responds to "NO"	<input type="checkbox"/> Drinks from a cup	<input type="checkbox"/> Points to 6 named body parts (nose, eyes...)	<input type="checkbox"/> Understands what to do when tired, cold or hungry (1 out of 3)	<input type="checkbox"/> Walks up stairs not holding on
<input type="checkbox"/> Cuddles	<input type="checkbox"/> Plays patty caka or waves "bye-bye"	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Names 1 animal picture	<input type="checkbox"/> Imitates a vertical line	<input type="checkbox"/> Toilet trained/night
<div style="border: 1px solid black; padding: 5px;"><input type="checkbox"/> AVOIDS EYE CONTACT</div>	<div style="border: 1px solid black; padding: 5px;"><input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> CONCERN THAT CHILD CAN'T HEAR <input type="checkbox"/> TUNES OUT</div>	<div style="border: 1px solid black; padding: 5px;"><input type="checkbox"/> AVOIDS EYE CONTACT <input type="checkbox"/> TOE WALKING</div>	<div style="border: 1px solid black; padding: 5px;">PERSISTENT <input type="checkbox"/> ROCKING <input type="checkbox"/> HEADBANGING <input type="checkbox"/> HANDFLAPPING</div>	<div style="border: 1px solid black; padding: 5px;"><input type="checkbox"/> AVOIDS INTERACTIVE PLAY</div>	<div style="border: 1px solid black; padding: 5px;">BY 5 YEARS Y N <input type="checkbox"/> Throws a ball overhand <input type="checkbox"/> Draws a three-part person <input type="checkbox"/> Copies a cross <input type="checkbox"/> Names four colors <input type="checkbox"/> Dresses without supervision</div>

PHYSICAL EXAMINATION (Please fill out completely)

Height _____ in _____ (% 'ile)	Physical examination: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, specify: _____
Weight _____ lbs BMI _____ (% 'ile)	
Head Circumference (up to 24 mos) _____ in _____ (% 'ile)	
Blood Pressure (after 3 years of age) _____ / _____	