

CENTER: SUNNY SKIES PRESCHOOL  
 NAME: 4228 - 10TH AVE  
 ADDRESS: 4301 - 10TH AVE  
 BROOKLYN, NY 11219  
 BORO: PH. 718-438-7040

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission \_\_\_ / \_\_\_ / \_\_\_

|                               |  |                               |  |                                 |   |       |
|-------------------------------|--|-------------------------------|--|---------------------------------|---|-------|
| NAME: (Last) (First) (Middle) |  |                               | SEX<br>F <input type="checkbox"/> M <input type="checkbox"/> |                                 | DATE OF BIRTH<br>Country/State of Birth |       |
| ADDRESS: (No.) (Street)       |  | (City/Boro)                   |  | (State)                         |   | (Zip) |
| MOTHER'S NAME: (First) (Last) |  | FATHER'S NAME: (First) (Last) |  | TELEPHONE NO.<br>Home:<br>Work: |   |       |
| FOSTER PARENT                 |  |                               |  |                                 |   |       |
| FOSTER AGENCY                 |  |                               | ADDRESS  |                                 | TELEPHONE #                             |       |
| LANGUAGE SPOKEN IN HOME       |  |                               |  |                                 |   |       |

| PERSONS TO CONTACT IN CASE OF EMERGENCY (Other Than Parent) |                                 |
|---|---------------------------------|
| NAME  | RELATIONSHIP TO CHILD           |
| ADDRESS   | TELEPHONE NO.<br>Home:<br>Work: |

| NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL |                |               |
|--|----------------|---------------|
| NAME   | CONTACT PERSON | PATIENT NO.   |
| ADDRESS                                      |                | TELEPHONE NO. |

|  |  |  |       |
|--|--|--|-------|
| SIGNIFICANT FAMILY HISTORY                   |  | IS CHILD ALLERGIC TO ANY:                      |       |
| <input type="checkbox"/> Sickle Cell         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Medications (Specify) | _____ |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> None                  | _____ |
| <input type="checkbox"/> Convulsive Disorder | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Foods (Specify)       | _____ |
| <input type="checkbox"/> Allergies (Specify) | <input type="checkbox"/> Vision        | <input type="checkbox"/> Insect Bites          | _____ |
| <input type="checkbox"/> OTHER (Specify)     | <input type="checkbox"/> Hearing       | <input type="checkbox"/> OTHER                 | _____ |

| HOSPITALIZATIONS AND ILLNESSES  | YES | NO | EXPLAIN |
|---|-----|----|---------|
| Has child ever been hospitalized or operated on?  |     |    |         |
| Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)? |     |    |         |
| Has child ever had a serious illness?   |     |    |         |

| SPECIAL HEALTH CONDITIONS | AGE IT BEGAN | TREATMENT/MEDICATIONS |
|---------------------------|--------------|-----------------------|
| (Long term or chronic)    |              |                       |
| 1. _____                  |              |                       |
| 2. _____                  |              |                       |
| 3. _____                  |              |                       |
| 4. _____                  |              |                       |
| 5. _____                  |              |                       |

\_\_\_\_\_ hereby certify that information provided herein is complete and accurate.

**CONSENT FOR EMERGENCY MEDICAL TREATMENT (REQUIRED FOR ADMISSION TO DAY CARE)**

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED  \_\_\_\_\_ DATE  \_\_\_\_\_ RELATIONSHIP  \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_

Notary Public or Commissioner of Deeds (OPTIONAL) \_\_\_\_\_ County of \_\_\_\_\_

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF