

Child's Name: _____

DOB ____/____/____

NEW ADMISSION RECORD

318KA-1 (REV. 8/06)

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit or Hemoglobin		Hct. % Hb gms %
Newborn Screening or Hemoglobin Electrophoresis		
Lead Risk Assessment		
Lead Screening (Venous preferred)		
Tuberculin Screening (PPD Mantoux)*		
Vision Screening		NL AB Red Reflex <input type="checkbox"/> <input type="checkbox"/> Cover Test <input type="checkbox"/> <input type="checkbox"/>
Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test. (ages 3-6 yrs)	FAR NEAR Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PF Both <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hearing Screening		
OTHER TESTS (Specify)		

* Not required at entry or for all children.

DENTAL ASSESSMENT Date: ____/____/____

1. Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____
2. Does the child sleep with a bottle? Yes No
3. Findings
 - A. No Visible Problems
(Clean mouth, no visible cavities, healthy gums)
 - B. Some Problems Detected
(Cavities, inflamed gums, open bite, malocclusion)
 - C. Severe Problems
(Baby bottle tooth decay; extensive cavities; abscesses)
 - D. Other (Specify):

Referral Suggested if B, C or D is checked

4. Has the child been referred to Dentist? Yes No

NUTRITIONAL UPDATE

- Up to age 1 year: Is the child on?
- Formula? No Yes
 - Breast milk? No Yes
 - Solid foods? No Yes
- 1 year and above:
- Is child bottle fed? No Yes
 - Type of diet? _____

Unusual dietary habits? No Yes, specify _____

Dietary restrictions? No Yes, specify _____

IMMUNIZATION HISTORY

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
Hep B					
DTaP					
Polio					
Hib					
PCV Pneumococcal					
MMR					
Varicella					
Hep A					
Influenza yearly 6-59 mos.					
Rotavirus					
Other					

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS

(Include all chronic conditions or conditions/findings needing follow-up)

1. _____
2. _____
3. _____
4. _____
5. _____

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____
2. Follow-up Needed Yes No
(Specify referral and date) _____
3. _____
4. _____
5. _____

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes No
2. Special recommendations for child? Specify treatments provided, or recommended evaluations. Does child require special education or early intervention? _____

Name/Address Stamp, if available:

Signature _____ Date of Exam. _____

Name (PLEASE PRINT) _____ Degree: _____

License No. _____ Telephone No. _____

Address _____