

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"/> <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"/> <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"/> <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: ____/____/____

- Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____
- Does the child sleep with a bottle? Yes No
- 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

- 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)

- _____
- _____
- _____
- _____
- _____

PLAN (Therapies, Referrals, F/U)

- Next Appointment Date ____/____/____
- Follow-up Needed Yes No
(Specify referral and date) _____
- _____
- _____
- _____