NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD'S MEDICAL RECORD

CHILD'S LAST NAME:	FIRST NAME:	DOB: / /	SEX: ☐ MALE ☐ FEMALE	CASE NUMBER:

ILLNESSES	DATE	ILLNESSES	DATE	ILLNESSES	DATE
Chicken Pox	/ /	RSV	/ /	Rickets	/ /
Diphtheria	/ /	Skin Condition	/ /	Kidney Disturbances	/ /
Measles	/ /	Encephalitis	/ /	Gonorrhea	/ /
Mumps	/ /	Seizures	/ /	Poliomyelitis	/ /
Whooping Cough	/ /	Diabetes	/ /		/ /
Asthma	/ /	Immune System	/ /		/ /
Meningitis	/ /	Chorea	/ /		/ /

ALLERGIES ☐ **No Known Allergies**

Other-enter category food, environment, medication	Allergen	Start Date	End Date
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

DURABLE MEDICAL EQUIPMENT

Adaptive Device	Start Date	Adaptive Device	Start Date	Adaptive Device	Start Date
Apnea Monitor	/ /	Cane	/ /	Crutches	/ /
Assistive Technology	/ /	Cervical Collar	/ /	Diabetic Equipment	/ /
Asthma Inhaler	/ /	Corrective Footwear/or Inserts	/ /	Epinephrine Auto Injector - Epi-Pen	/ /
Brace – Body	/ /	Helmet	/ /	Eye Glasses or Contact Lenses	/ /
Brace – Limb	/ /	Nebulizer	/ /	Hearing Aids	/ /
	/ /	CPAP	/ /		/ /

DATE	SURGERIES /ACCIDENTS REQUIRING MEDICAL TREATMENT	DATE	
/ /		/ /	
/ /		/ /	
/ /		/ /	

DEVELOPMENTAL/FAMILY MEDICAL HISTORY:

WAS AN EARLY INTERVENTION REFERRAL MADE? ☐ YES IF YES, DATE: / / ☐ NO ☐ N/A

TESTS	DATE	RESULT	TESTS	DATE	RESULT
Tuberculin Tests	/ /		Blood Count Complete	/ /	
PPD	/ /		READ:	/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
X-Rays:	/ /		EEG	/ /	
X-Rays:	/ /		EKG	/ /	
Urinalysis	/ /		Dental exams	/ /	
Vision exams	/ /			/ /	

CHILD'S LAST NAME:	FIRST NAME:	DOB: / /	SEX: ☐ MALE ☐ FEMALE	CASE NUMBER:

MEDICATIONS	DOSAGE	INSTRUCTIONS

IMMUNIZATIONS

VACCINES	Dates immunized							
Hepatitis B	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Rotavirus	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Diphtheria, Tetanus, Pertussis (DTaP)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Tetanus, Diphtheria Pertussis (Tdap) 2	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Haemophilus influenza type b (Hib)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Disease (PVC) 3	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Measles, Mumps, Rubella (MMR) 4	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Varicella (Chickenpox)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Human Papillomavirus (HPV) 5	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Meningococcal Disease 6	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
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This is aligned with national guidelines set by the Advisory Committee on Immunization Practices and recommendations by the CDC.

Is consent of child's parent or guardian for routine medical care on file? ☐ **Yes** ☐ **No**									
*** A copy of the well visit can be attached to this form A signature is required.**									
Present Concern:									
EXAM:	DATE: / /				**BODY MASS INDEX**	DATE: / /				**BODY MASS INDEX**
Vitals: Height, Weight, Temp, Blood Pressure	H	W	T	BP		H	W	T	BP	

Head/Scalp				
Eyes/Pupillary Reaction				
Visual Acuity				
Eye Grounds				
Ears, Otoscopic				
Hearing				
Nose				
Teeth and Mouth				
Throat Pharynx				
Tonsils, Adenoids				
Neck				
Chest and Spine				
Heart				
Blood Pressure				
Lungs				
Abdomen				
Genitalia				
Secondary Sex Characteristics				
Extremities				
Nervous System				
Lymphatic System				
Skin				
Nutrition				
Posture				
Signs of Endocrine				
Urinalysis				
Last Dental Exam	**DATE: / /**	Result:	**/ /**	Result:
Last Eye Exam	**DATE: / /**	Result:	**/ /**	Result:

ADDITIONAL MEDICAL ISSUES:

RECOMMENDATIONS:		RECOMMENDATIONS:	
Signature:	Date: **/ /**	Signature:	Date: **/ /**
Medical Provider Name Stamp:		Medical Provider Name Stamp:	

CHILD'S LAST NAME:	FIRST NAME:	DOB: / /	SEX: ☐ MALE ☐ FEMALE	CASE NUMBER:

Is consent of child's parent or guardian for routine medical care on file? ☐ **Yes** ☐ **No**

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Present Concern:

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ADDITIONAL MEDICAL ISSUES:

RECOMMENDATIONS:		RECOMMENDATIONS:	
Signature:	Date: / /	Signature	Date: / /
Medical Provider Name Stamp		Medical Provider Name Stamp	