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**Pediatric Admissions Form**

**Child’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male\_\_\_\_Female\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please provide legal guardian paperwork)

**In Case of Emergency**

Hospital Preference in Case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**Pregnancy and Delivery Information**

|  |  |
| --- | --- |
| Premature Labor \_\_\_\_\_\_ | Toxemia: \_\_\_\_\_\_ |
| Multiple Births \_\_\_\_\_\_ | Substance Exposure: \_\_\_\_\_ |
| With Complications: \_\_\_\_\_\_ | Positive for Strep B: \_\_\_\_\_\_ |
| Without Complications: \_\_\_\_\_\_ | Gestational Diabetes: \_\_\_\_\_\_ |
| Positive for Cytomegalovirus (CMV): \_\_\_\_\_\_ | Other: \_\_\_\_\_\_ |

Length of Pregnancy (weeks): \_\_\_\_\_\_\_\_\_\_\_\_\_Prenatal Care: \_\_\_\_\_\_yes\_\_\_\_\_\_\_no

**Delivery**

|  |  |
| --- | --- |
| Umbilical Cord Complications: \_\_\_\_\_\_ | Premature Rupture of Membranes: \_\_\_\_\_\_ |
| Abruptio Placenta: \_\_\_\_\_\_ | Meconium Aspiration: \_\_\_\_\_\_ |
| Placenta Previa: \_\_\_\_\_\_ | Vacuum: \_\_\_\_\_\_ |
| Use of Forceps: \_\_\_\_\_\_ | Breech Presentation: \_\_\_\_\_\_ |
| Prolapsed Cord: \_\_\_\_\_\_ | Uterine Rupture: \_\_\_\_\_\_ |
| With Complications: \_\_\_\_\_\_\_ | Transverse Presentation: \_\_\_\_\_\_ |
| Without Complications: \_\_\_\_\_\_ | Other: \_\_\_\_\_\_ |

Delivery was: Emergency C-Section\_\_\_\_\_\_\_\_ C-Section\_\_\_\_\_\_\_\_\_Vaginal\_\_\_\_\_\_\_\_\_

Birth Weight \_\_\_\_\_\_\_\_\_Birth Height\_\_\_\_\_\_\_\_\_

Apgar 1 min\_\_\_\_\_\_\_5 min\_\_\_\_\_\_10 min\_\_\_\_\_\_

**Following Birth**

|  |  |
| --- | --- |
| Failure to Thrive \_\_\_\_\_\_ | Anemia of Prematurity\_\_\_\_\_\_ |
| Cleft Lip\_\_\_\_\_\_ | Intrauterine Growth Retardation\_\_\_\_\_\_ |
| Brohoplumonary Dysplasia (BPD)\_\_\_\_\_\_ | Hyperbilirubinemia\_\_\_\_\_\_\_ |
| IVH Bleed Grade IV\_\_\_\_\_\_ | Respiratory Synctial Virus (RSV)\_\_\_\_\_\_ |
| Retinopathy of Prematurity (ROP)\_\_\_\_\_\_ | Necrotizing Enterocolitis (NEC)\_\_\_\_\_\_ |
| Neonatal Hypoxia\_\_\_\_\_ | Intrauterine Growth Retardation (IUGR)\_\_\_\_\_\_ |
| VP Shunt\_\_\_\_\_ | Patent Ductus Arteriosus (PDA) \_\_\_\_\_\_ |
| IVH Bleed Grade I\_\_\_\_\_\_\_ | Club Foot\_\_\_\_\_\_ |
| IVH Bleed Grade II\_\_\_\_\_\_\_ | VP Shunt\_\_\_\_\_\_ |
| IVH Bleed Grade III\_\_\_\_\_\_\_ | Respiratory Distress Syndrome (RDS) \_\_\_\_\_\_ |
| Oxygen Dependency\_\_\_\_\_\_ | ECMO # of Days\_\_\_\_\_\_ |
| Cleft Palate\_\_\_\_\_\_ | Ventilator Dependency # of Days\_\_\_\_\_\_ |
| Other: |  |

Suspected Diagnosis or Syndromes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental Milestones (age at which your child achieved these skills)**

Creeps/Crawls Alone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rolled Over \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grabs Toys\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sits Alone without support\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Held head up alone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walked\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulls Self Up to Standing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child get around the house?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Issues**

|  |  |
| --- | --- |
| Traumatic Brain Injury (TBI)\_\_\_\_\_\_ | Arteriovenous Malformation\_\_\_\_\_\_ |
| Chronic Ear Infections\_\_\_\_\_\_\_ | Constipation/Diarrhea\_\_\_\_\_\_\_ |
| Sleep Problems\_\_\_\_\_\_\_ | Anoxic Brain Injury\_\_\_\_\_\_ |
| Colic\_\_\_\_\_\_ | Reflux\_\_\_\_\_\_ |
| Allergies\_\_\_\_\_\_ | Cerebral Vascular Accident (CVA/stroke)\_\_\_\_\_ |
| Cardiac Condition\_\_\_\_\_\_ | Seizure Disorder\_\_\_\_\_\_\_\_\_last seizure\_\_\_\_\_\_\_ |
| Tube Feeding\_\_\_\_\_\_ | Asthma/Respiratory\_\_\_\_\_\_ |
| Other:  |  |

Vitamins, Herbs, Minerals, Homeopathic

**Hearing Vision**

|  |
| --- |
| Never Tested |
| No Concerns |
| Never Tested, Have Concerns |
| Test Results Date |
| Results |
| Specialist Seen |

|  |
| --- |
| Never Tested |
| No Concerns |
| Never Tested, Have Concerns |
| Test Result Date |
| Results |

**Precautions:**

|  |
| --- |
| None |
| Allergies |
| Seizure Condition |
| Shunt |
| Baclofen Pump |
| Vagal Nerve Stimulator |
| Other |

Medical Conditions

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Concerns/Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite Toys/Play activities (super heroes, cartoon figures, ipad games) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which hand does your child use primarily: Right \_\_\_\_\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Both\_\_\_\_\_\_\_\_

Does child lose balance or fall a lot: yes\_\_\_\_\_\_\_\_\_\_no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child visually look at other people or toys without difficulty: yes\_\_\_\_\_\_\_\_\_\_\_\_no\_\_\_\_\_\_\_\_\_\_

**Education**

Grade in School\_\_\_\_\_\_\_\_\_\_\_\_Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have an IEP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive therapy at school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child currently or previously received any of these therapy services:

Behavior\_\_\_\_\_

Nutrition\_\_\_\_\_\_

Occupational\_\_\_\_\_\_

Physical\_\_\_\_\_\_

Speech/language\_\_\_\_\_\_

Social\_\_\_\_\_\_

Vision\_\_\_\_\_\_

Person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_