CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ __

Phone Numbers
Home _____
Cell _____
Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** Last Name | First Name
☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER

If "yes" to any item, please explain (attach addendum, if needed)

Birth history *(age 0-6 yrs)*
☐ Uncomplicated ☐ Premature: _____ weeks gestation
☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* _____
☐ Foods *(list)* _____
☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*
☐ None ☐ Yes *(list below)*

Dietary Restrictions
☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)
Weight _____ **kg** (__ __ %ile)
BMI _____ **kg/m²** (__ __ %ile)
Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)
Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____
☐ Communication/Language _____
☐ Social/Emotional _____
☐ Adaptive/Self-Help _____
☐ Motor _____

SCREENING TESTS

	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *Specify:* _____	__/__/__ :	_____	__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions *(specify)* _____
Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other _____

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __/__/__

DOHMH ONLY PROVIDER I.D.

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)
Comments

Date Reviewed: __/__/__ **I.D. NUMBER**
REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian