

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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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 _____ Phone Numbers
Number _____ Home _____
Cell _____
Work _____

Health insurance Yes No Parent/Guardian Last Name _____ First Name _____
(including Medicaid)? No 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?
If persistent, check all current medication(s): Inhaled corticosteroid Other controller Quick relief med Oral steroid None
 Attention Deficit Hyperactivity Disorder Orthopedic injury/disability
 Chronic or recurrent otitis media Seizure disorder
 Congenital or acquired heart disorder Speech, hearing, or visual impairment
 Developmental/learning problem Tuberculosis (latent infection or disease)
 Diabetes (attach MAF) Other (specify) _____

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

Dietary Restrictions
 None Yes (list below)

Explain all checked items above or on addendum

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	<input type="checkbox"/> HEENT	Ni Abnl	<input type="checkbox"/> Lymph nodes	Ni Abnl	<input type="checkbox"/> Abdomen	Ni Abnl	<input type="checkbox"/> Skin	Ni Abnl	<input type="checkbox"/> Psychosocial Development
<input type="checkbox"/> DENTAL	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Language	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/spine	<input type="checkbox"/> 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
Lead Risk Assessment (annually, age 6 mo-6 yrs)	_____/_____/_____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk
Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	_____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Hemoglobin or Hematocrit (age 9-12 mo)	_____/_____/_____ _____ g/dL _____ %

Head Start Only

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 _____/_____/_____
PPD/Mantoux read _____/_____/_____
Interferon Test _____/_____/_____
Chest x-ray (if PPD or Interferon positive) _____/_____/_____
Vision (required for new school entrants and children age 4-7 yrs) _____/_____/_____
 with glasses

Induration _____ mm
 Neg Pos
 Neg Pos
 NI Not Indicated
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 _____/_____/_____
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.

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Health Care Provider Name and Degree (print) _____

Provider License No. and State _____

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

Facility Name _____

National Provider Identifier (NPI) _____

Comments _____

Address _____

City _____

State _____

Zip _____

Date Reviewed: ____/____/____

I.D. NUMBER

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Telephone (____) _____ - _____

Fax (____) _____ - _____

REVIEWER: _____