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 ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ *If persistent, check all current medication(s):*

☐ 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:

Nl Abnl		*Nl Abnl*		*Nl Abnl*		*Nl Abnl*		*Nl Abnl*	
☐ ☐	HEENT	☐ ☐	Lymph nodes	☐ ☐	Abdomen	☐ ☐	Skin	☐ ☐	Psychosocial Development
☐ ☐	Dental	☐ ☐	Lungs	☐ ☐	Genitourinary	☐ ☐	Neurological	☐ ☐	Language
☐ ☐	Neck	☐ ☐	Cardiovascular	☐ ☐	Extremities	☐ ☐	Back/spine	☐ ☐	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)*	__/__/__	☐ Nl ☐ 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 __/__/__

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___ - ____ | Fax (___) ___ - ____

DOHMH ONLY **PROVIDER I.D.**

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