

# 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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other			
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____	Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Foster Parent <input type="checkbox"/>		

## TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____	<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> If persistent, check all current medication(s): <input type="checkbox"/> Orthopedic injury/disability	<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
<b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	<input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Other (specify) _____	<b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)

Explain all checked items above or on addendum

<b>PHYSICAL EXAMINATION</b> Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age <2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	<b>General Appearance:</b> NI Abnl NI Abnl NI Abnl NI Abnl NI Abnl <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <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"/> Extremities <input type="checkbox"/> Back/spine <input type="checkbox"/> Behavioral <b>Describe abnormalities:</b>
---	--

<b>DEVELOPMENTAL (age 0-6 yrs)</b> <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	<b>SCREENING TESTS</b> <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) Date Done: ____/____/____ Results: _____ μg/dL <b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) Date Done: ____/____/____ Results: <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk <b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> OAE <b>Head Start Only</b> <b>Hemoglobin or Hematocrit</b> (age 9-12 mo) Date Done: ____/____/____ Results: _____ g/dL _____ %	<b>Tuberculosis</b> 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 Date Done: ____/____/____ Induration _____ mm PPD/Mantoux read Date Done: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test Date Done: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive) Date Done: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl <b>Vision</b> (required for new school entrants and children age 4-7 yrs) Date Done: ____/____/____ <input type="checkbox"/> with glasses Acuity Right ____ / ____ Left ____ / ____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
--	--	---

<b>IMMUNIZATIONS – DATES</b> CIR Number of Child _____ Hep B _____ Rotavirus _____ DTP/DTap/DT _____ Hib _____ PCV _____ Polio _____ Influenza _____ MMR _____ Varicella _____ Td _____ Tdap _____ Hep A _____ Meningococcal _____ HPV _____ Other, specify: _____
--

<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____
--	---

Health Care Provider Signature	Date	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City State Zip	Date Reviewed: _____ I.D. NUMBER _____
Telephone (____) _____ - _____	Fax (____) _____ - _____	REVIEWER: _____