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 O Female O Male

Date of Birth *(Month/Day/Year)* ___/___/___

Child's Address

Hispanic/Latino? O Yes O No

Race *(Check ALL that apply)* O American Indian O Asian O Black O White O Native Hawaiian/Pacific Islander O Other ___

City/Borough | State | Zip Code

School/Center/Camp Name

District ___ Number ___

Phone Numbers

Home ___

Cell ___

Work ___

Health insurance (including Medicaid)? O Yes O No

O **Parent/Guardian** Last Name | First Name

O **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)*

O Uncomplicated O Premature: ___ weeks gestation

O Complicated by ___

Allergies O None O Epi pen prescribed

O Drugs *(list)* ___

O Foods *(list)* ___

O Other *(list)* ___

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

O Asthma *(check severity and attach MAF/Asthma Action Plan):* O Intermittent O Mild Persistent O Moderate Persistent O Severe Persistent

If persistent, check all current medication(s): O Inhaled corticosteriod O Other controller O Quick relief med O Oral steroid O None

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

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

O None O Yes *(list below)*

Dietary Restrictions

O None O 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	
O	O	HEENT	O	O	Lymph nodes	O	O	Abdomen	O	O	Skin	O	O	Psychosocial Development
O	O	Dental	O	O	Lungs	O	O	Genitourinary	O	O	Neurological	O	O	Language
O	O	Neck	O	O	Cardiovascular	O	O	Extremities	O	O	Back/spine	O	O	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* O Within normal limits

If delay suspected, specify below

O Cognitive *(e.g., play skills)* ___

O Communication/Language ___

O Social/Emotional ___

O Adaptive/Self-Help ___

O 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)*	___/___/___	O At risk *(do BLL)* O Not at risk
Hearing O Pure tone audiometry O OAE	___/___/___	O Normal O 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*	___/___/___	O Neg O Pos
Interferon Test	___/___/___	O Neg O Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/___	O Nl O Abnl O Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	___/___/___ O with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus O No O 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 O Full physical activity O Full diet

O Restrictions *(specify)*

Follow-up Needed O No O Yes, for ___ Appt. date: ___/___/___

Referral(s): O None O Early Intervention O Special Education O Dental O Vision

O Other ___

ASSESSMENT O **Well Child** (V20.2) O **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