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)

Parents/Guardian
City/Borough
State
Zip Code
School/Center/Camp Name
District/Number
Health insurance  O Yes  O No
Healthcare insurance (including Medicaid)  O Yes  O No
Parent/Guardian Last Name
First Name

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
- Food
- Drug
- Epi pen prescribed
- Other

Immunizations – Dates

IMMUNIZATIONS – DATES

CIR Number of Child

Hep B
Rotavirus
DT/PDaDT/PDT
Hib
PCV
Polio

RECOMMENDATIONS

O Full physical activity
O Full diet
O Restrictions (specify)

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

Referred(s)
O None  O Early Intervention  O Special Education  O Dental  O Vision  O Other

Health Care Provider Signature

Date

DOHMH ONLY

Provider License No. and State

Provider Name

Provider Type (Ex. MD)

Facility Name

National Provider Identifier (NPI)

Address

City
State
Zip

Telephone
Fax

Comments

Type of Exam

Date

T.D. Number

REVIEWER:

CHILD & ADOLESCENT HEALTH EXAMINATION FORM
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE – DEPARTMENT OF EDUCATION

CH-205 (5/08)

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