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** ☐ **Foster Parent** 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 ☐ 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
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ 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 ______ %

Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*	*Date Done*	*Results*
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 ___/___/___ | **DOHMH ONLY** **PROVIDER I.D.**

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

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

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