

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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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 ☐ Yes (including Medicaid)? ☐ No		☐ Parent/Guardian Last Name ☐ Foster Parent		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 ☐ Orthopedic injury/disability ☐ Chronic or recurrent otitis media ☐ Seizure disorder ☐ Congenital or acquired heart disorder ☐ Speech, hearing, or visual impairment ☐ Developmental/learning problem ☐ Tuberculosis (latent infection or disease) ☐ Diabetes (attach MAF) ☐ Other (specify) _____		Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below) _____ _____ Dietary Restrictions ☐ None ☐ Yes (list below) _____	
Explain all checked items above or on addendum					

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:

NI Abnl	HEENT	NI Abnl	Lymph nodes	NI Abnl	Abdomen	NI Abnl	Skin	NI Abnl	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 <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>____ μg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td>☐ At risk (do BLL) ☐ Not at risk</td> </tr> <tr> <td>Hearing ☐ Pure tone audiometry ☐ OAE</td> <td>____/____/____</td> <td>☐ Normal ☐ Abnormal</td> </tr> <tr> <td colspan="3" style="text-align: center;">Head Start Only</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>			Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ 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 <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>PPD/Mantoux placed</td> <td>____/____/____</td> <td>Induration _____ mm</td> </tr> <tr> <td>PPD/Mantoux read</td> <td>____/____/____</td> <td>☐ Neg ☐ Pos</td> </tr> <tr> <td>Interferon Test</td> <td>____/____/____</td> <td>☐ Neg ☐ Pos</td> </tr> <tr> <td>Chest x-ray (if PPD or Interferon positive)</td> <td>____/____/____</td> <td>☐ NI ☐ Not ☐ Abnl Indicated</td> </tr> <tr> <td>Vision (required for new school entrants and children age 4-7 yrs)</td> <td>____/____/____ ☐ with glasses</td> <td>Acuity Right ____ / ____ Left ____ / ____ Strabismus ☐ No ☐ Yes</td> </tr> </tbody> </table>			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)	____/____/____	☐ NI ☐ Not ☐ Abnl Indicated	Vision (required for new school entrants and children age 4-7 yrs)	____/____/____ ☐ with glasses	Acuity Right ____ / ____ Left ____ / ____ Strabismus ☐ No ☐ Yes
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IMMUNIZATIONS – DATES

CIR Number of Child

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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.

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Health Care Provider Name and Degree (print)

Provider License No. and State

Facility Name

National Provider Identifier (NPI)

Address City State Zip

Date Reviewed: ____/____/____ I.D. NUMBER

Telephone (____) _____ - _____ Fax (____) _____ - _____

REVIEWER: _____