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 ☐ 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)* ________

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 ______ %

	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*	__ / __ / __	☐ 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 ☐☐☐☐☐☐☐☐☐

Vaccine				
Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Vaccine			
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 __ / __ / __

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