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)

☐ Premature: _____ weeks gestation

Complicated by _____

☐ None ☐ Epi pen prescribed

_____

_____

_____

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

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 ☐☐☐☐☐☐☐☐☐☐

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 __ __ / ___ ___ / ___ ___

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: | I.D. NUMBER ☐☐☐☐☐☐☐

Asthma *(check severity and attach MAF/Asthma Action Plan):*

Uncomplicated

Complicated by

Allergies

Drugs *(list)*

Foods *(list)*

Other *(list)*

If persistent, check all current medication(s):

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)* _____