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** O Female O Male | **Date of Birth** *(Month/Day/Year)* / / 2011

Child's Address | **Hispanic/Latino?** O Yes O No | **Race** *(Check ALL that apply)* O American Indian O Asian O Black O White O Native Hawaiian/Pacific Islander O Other

City/Borough | State N.Y. | Zip Code | School/Center/Camp Name | District Number | **Phone Numbers** *Home* *Cell* *Work*

Health insurance (including Medicaid)? O Yes O No | O **Parent/Guardian** Last Name First Name O **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

O Uncomplicated O Premature: _____ weeks gestation

O Complicated by _____

Allergies O None O Epi pen prescribed

O Drugs *(list)* _____

O Foods *(list)* _____

O Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

O Asthma *(check severity and attach MAF/Asthma Action Plan):* O Intermittent O Mild Persistent O Moderate Persistent O Severe Persistent

If persistent, check all current medication(s): O Inhaled corticosteriod O Other controller O Quick relief med O Oral steroid O None

O Attention Deficit Hyperactivity Disorder
O Chronic or recurrent otitis media
O Congenital or acquired heart disorder
O Developmental/learning problem
O Diabetes *(attach MAF)*
O Orthopedic injury/disability
O Seizure disorder
O Speech, hearing, or visual impairment
O Tuberculosis *(latent infection or disease)*
O **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

O None O Yes *(list below)*

_____

Dietary Restrictions

O None O 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	
O	O	HEENT	O	O	Lymph nodes	O	O	Abdomen	O	O	Skin	O	O	Psychosocial Development
O	O	Dental	O	O	Lungs	O	O	Genitourinary	O	O	Neurological	O	O	Language
O	O	Neck	O	O	Cardiovascular	O	O	Extremities	O	O	Back/spine	O	O	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* O Within normal limits

If delay suspected, specify below

O Cognitive *(e.g., play skills)* _____

O Communication/Language _____

O Social/Emotional _____

O Adaptive/Self-Help _____

O 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)*	___/___/___	O At risk *(do BLL)* O Not at risk
Hearing O Pure tone audiometry O OAE	___/___/___	O Normal O 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*	___/___/___	O Neg O Pos
Interferon Test	___/___/___	O Neg O Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/___	O Nl O Abnl O Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	___/___/___ O with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus O No O 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 O Full physical activity O Full diet

O Restrictions *(specify)*

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

Referral(s): O None O Early Intervention O Special Education O Dental O Vision

O Other _____

ASSESSMENT O **Well Child** (V20.2) O **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