

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 <input type="radio"/> Female <input type="radio"/> Male	Date of Birth (Month/Day/Year) / 2012	
Child's Address			Hispanic/Latino? <input type="radio"/> Yes <input type="radio"/> No	Race (Check ALL that apply) <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other	
City/Borough	State N.Y.	Zip Code	School/Center/Camp Name	District Number	Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="radio"/> Yes <input type="radio"/> No	Parent/Guardian <input type="radio"/> Parent/Guardian <input type="radio"/> 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) <input type="radio"/> Uncomplicated <input type="radio"/> Premature: _____ weeks gestation <input type="radio"/> Complicated by _____ Allergies <input type="radio"/> None <input type="radio"/> Epi pen prescribed <input type="radio"/> Drugs (list) _____ <input type="radio"/> Foods (list) _____ <input type="radio"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? <input type="radio"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="radio"/> Intermittent <input type="radio"/> Mild Persistent <input type="radio"/> Moderate Persistent <input type="radio"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="radio"/> Inhaled corticosteroid <input type="radio"/> Other controller <input type="radio"/> Quick relief med <input type="radio"/> Oral steroid <input type="radio"/> None <input type="radio"/> Attention Deficit Hyperactivity Disorder <input type="radio"/> Orthopedic injury/disability <input type="radio"/> Chronic or recurrent otitis media <input type="radio"/> Seizure disorder <input type="radio"/> Congenital or acquired heart disorder <input type="radio"/> Speech, hearing, or visual impairment <input type="radio"/> Developmental/learning problem <input type="radio"/> Tuberculosis (latent infection or disease) <input type="radio"/> Diabetes (attach MAF) <input type="radio"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="radio"/> None <input type="radio"/> Yes (list below) _____ Dietary Restrictions <input type="radio"/> None <input type="radio"/> Yes (list below) _____
<i>Explain all checked items above or on addendum</i>		

PHYSICAL EXAMINATION Height _____ cm (_____%ile) Weight _____ kg (_____%ile) BMI _____ kg/m ² (_____%ile) Head Circumference (age ≤2 yrs) _____ cm (_____%ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="1"><tr><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td></tr><tr><td><input type="radio"/> HEENT</td><td><input type="radio"/> Lymph nodes</td><td><input type="radio"/> Abdomen</td><td><input type="radio"/> Skin</td><td><input type="radio"/> Psychosocial Development</td></tr><tr><td><input type="radio"/> Dental</td><td><input type="radio"/> Lungs</td><td><input type="radio"/> Genitourinary</td><td><input type="radio"/> Neurological</td><td><input type="radio"/> Language</td></tr><tr><td><input type="radio"/> Neck</td><td><input type="radio"/> Cardiovascular</td><td><input type="radio"/> Extremities</td><td><input type="radio"/> Back/spine</td><td><input type="radio"/> Behavioral</td></tr></table> Describe abnormalities: _____	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<input type="radio"/> HEENT	<input type="radio"/> Lymph nodes	<input type="radio"/> Abdomen	<input type="radio"/> Skin	<input type="radio"/> Psychosocial Development	<input type="radio"/> Dental	<input type="radio"/> Lungs	<input type="radio"/> Genitourinary	<input type="radio"/> Neurological	<input type="radio"/> Language	<input type="radio"/> Neck	<input type="radio"/> Cardiovascular	<input type="radio"/> Extremities	<input type="radio"/> Back/spine	<input type="radio"/> Behavioral
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DEVELOPMENTAL (age 0-6 yrs) <input type="radio"/> Within normal limits If delay suspected, specify below <input type="radio"/> Cognitive (e.g., play skills) _____ <input type="radio"/> Communication/Language _____ <input type="radio"/> Social/Emotional _____ <input type="radio"/> Adaptive/Self-Help _____ <input type="radio"/> 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><input type="radio"/> At risk (do BLL) <input type="radio"/> Not at risk</td></tr><tr><td>Hearing <input type="radio"/> Pure tone audiometry <input type="radio"/> OAE</td><td>____/____/____</td><td><input type="radio"/> Normal <input type="radio"/> Abnormal</td></tr><tr><td>Hemoglobin or Hematocrit (age 9-12 mo)</td><td>____/____/____</td><td>____ g/dL ____ %</td></tr></tbody></table> <p style="text-align: center;">Head Start Only</p>		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)	____/____/____	<input type="radio"/> At risk (do BLL) <input type="radio"/> Not at risk	Hearing <input type="radio"/> Pure tone audiometry <input type="radio"/> OAE	____/____/____	<input type="radio"/> Normal <input type="radio"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> <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><input type="radio"/> Neg <input type="radio"/> Pos</td></tr><tr><td>Interferon Test</td><td>____/____/____</td><td><input type="radio"/> Neg <input type="radio"/> Pos</td></tr><tr><td>Chest x-ray (if PPD or Interferon positive)</td><td>____/____/____</td><td><input type="radio"/> NI <input type="radio"/> Not Indicated <input type="radio"/> Abnl</td></tr><tr><td>Vision (required for new school entrants and children age 4-7 yrs)</td><td>____/____/____</td><td>Acuity Right ____ / ____ Left ____ / ____ <input type="radio"/> with glasses <input type="radio"/> No <input type="radio"/> Yes</td></tr></tbody></table>		Date Done	Results	PPD/Mantoux placed	____/____/____	Induration _____ mm	PPD/Mantoux read	____/____/____	<input type="radio"/> Neg <input type="radio"/> Pos	Interferon Test	____/____/____	<input type="radio"/> Neg <input type="radio"/> Pos	Chest x-ray (if PPD or Interferon positive)	____/____/____	<input type="radio"/> NI <input type="radio"/> Not Indicated <input type="radio"/> Abnl	Vision (required for new school entrants and children age 4-7 yrs)	____/____/____	Acuity Right ____ / ____ Left ____ / ____ <input type="radio"/> with glasses <input type="radio"/> No <input type="radio"/> Yes
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IMMUNIZATIONS - DATES CIR Number of Child _____ <table border="1"><tr><td>Hep B</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Rotavirus</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>DTP/DTaP/DT</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Hib</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>PCV</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Polio</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr></table>	Hep B	____/____/____	____/____/____	____/____/____	____/____/____	Rotavirus	____/____/____	____/____/____	____/____/____	____/____/____	DTP/DTaP/DT	____/____/____	____/____/____	____/____/____	____/____/____	Hib	____/____/____	____/____/____	____/____/____	____/____/____	PCV	____/____/____	____/____/____	____/____/____	____/____/____	Polio	____/____/____	____/____/____	____/____/____	____/____/____	<table border="1"><tr><td>Influenza</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>MMR</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Varicella</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Td</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Tdap</td><td>____/____/____</td><td>Hep A</td><td>____/____/____</td></tr><tr><td>Meningococcal</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>HPV</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr><tr><td>Other, specify:</td><td>____/____/____</td><td>____/____/____</td><td>____/____/____</td></tr></table>	Influenza	____/____/____	____/____/____	____/____/____	MMR	____/____/____	____/____/____	____/____/____	Varicella	____/____/____	____/____/____	____/____/____	Td	____/____/____	____/____/____	____/____/____	Tdap	____/____/____	Hep A	____/____/____	Meningococcal	____/____/____	____/____/____	____/____/____	HPV	____/____/____	____/____/____	____/____/____	Other, specify:	____/____/____	____/____/____	____/____/____
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RECOMMENDATIONS <input type="radio"/> Full physical activity <input type="radio"/> Full diet <input type="radio"/> Restrictions (specify) _____ Follow-up Needed <input type="radio"/> No <input type="radio"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="radio"/> None <input type="radio"/> Early Intervention <input type="radio"/> Special Education <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Other _____	ASSESSMENT <input type="radio"/> Well Child (V20.2) <input type="radio"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____