

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
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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="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____	
City/Borough	State	Zip Code	School/Center/Camp Name	District _____ Number _____	Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> 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="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> 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): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> 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:					
<input type="checkbox"/> NI <input type="checkbox"/> Abnl	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Psychosocial Development
<input type="checkbox"/> DENTAL	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Back/spine	<input type="checkbox"/> Language
<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Behavioral		
Describe abnormalities:					

DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS	Date Done	Results	Date Done	Results		
	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ μg/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>	PPD/Mantoux placed	____/____/____	Induration _____ mm
	Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	____ μg/dL		PPD/Mantoux read	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Interferon Test	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	
Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Chest x-ray (if PPD or Interferon positive)	____/____/____	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl		
Head Start Only			Vision (required for new school entrants and children age 4-7 yrs)	____/____/____	Acuity Right ____ / ____ Left ____ / ____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes		

IMMUNIZATIONS - DATES

CIR Number of Child	____	____	____	____	____	____	____
Hep B	____/____/____	____/____/____	____/____/____	Influenza	____/____/____	____/____/____	____/____/____
Rotavirus	____/____/____	____/____/____	____/____/____	MMR	____/____/____	____/____/____	____/____/____
DTP/DTaP/DT	____/____/____	____/____/____	____/____/____	Varicella	____/____/____	____/____/____	____/____/____
Hib	____/____/____	____/____/____	____/____/____	Td	____/____/____	____/____/____	____/____/____
PCV	____/____/____	____/____/____	____/____/____	Tdap	____/____/____	____/____/____	____/____/____
Polio	____/____/____	____/____/____	____/____/____	Hep A	____/____/____	____/____/____	____/____/____
				Meningococcal	____/____/____	____/____/____	____/____/____
				HPV	____/____/____	____/____/____	____/____/____
				Other, Specify:	____/____/____	____/____/____	____/____/____

RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date ____/____/____	DOHMH ONLY PROVIDER 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 (____) _____ - _____	State	I.D. NUMBER
Fax (____) _____ - _____	Zip	REVIEWER: _____