

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
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name
		Foster Parent		Phone Numbers Home Cell Work

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 <i>If persistent, check all current medication(s):</i> <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/m² (____ %ile)
 Head Circumference (age ≤2 yrs) _____ cm (____ %ile)
 Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>
<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"/> Language
<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine	<input type="checkbox"/> 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) <i>(required at age 1 yr and 2 yrs and for those at risk)</i>	____/____/____	_____ µg/dL
Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk
Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %

Head Start Only

Tuberculosis

Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school

	Date Done	Results
PPD/Mantoux placed	____/____/____	Induration _____ mm
PPD/Mantoux read	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
Interferon Test	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
Chest x-ray <i>(if PPD or Interferon positive)</i>	____/____/____	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl
Vision <i>(required for new school entrants and children age 4-7 yrs)</i>	____/____/____	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	____/____/____
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	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: _____