

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 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 Yes No Parent/Guardian Last Name _____ First Name _____
(Including Medicaid)? No 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)
 Uncomplicated Premature: _____ weeks gestation
 Complicated by _____

Allergies None Epi pen prescribed
 Drugs (list) _____
 Foods (list) _____
 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): Intermittent Mild Persistent Moderate Persistent Severe Persistent
If persistent, check all current medication(s): Inhaled corticosteroid Other controller Quick relief med Oral steroid None
 Attention Deficit Hyperactivity Disorder Orthopedic Injury/disability
 Chronic or recurrent otitis media Seizure disorder
 Congenital or acquired heart disorder Speech, hearing, or visual impairment
 Developmental/learning problem Tuberculosis (latent infection or disease)
 Diabetes (attach MAF) Other (specify) _____

Medications (attach MAF if in-school medication needed)
 None Yes (list below) _____

Dietary Restrictions
 None Yes (list below) _____

Explain all checked items above or on addendum

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>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI 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

Test	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 ____ %

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

Test	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 ____/____/____

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 PROVIDER I.D. _____

TYPE OF EXAM: NAE Current NAE Prior Year(s)
 Comments _____

Date Reviewed: ____/____/____ **I.D. NUMBER** _____

REVIEWER: _____