# 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** ☐ 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 (including Medicaid)?** ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **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)*

☐ 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 corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

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

***Explain all checked items above or on addendum***

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

**Dietary Restrictions**
☐ None ☐ 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:**

| | NI | Abnl |
|---|---|---|
| HEENT | ☐ | ☐ |
| Dental | ☐ | ☐ |
| Neck | ☐ | ☐ |
| Lymph nodes | ☐ | ☐ |
| Lungs | ☐ | ☐ |
| Cardiovascular | ☐ | ☐ |
| Abdomen | ☐ | ☐ |
| Genitourinary | ☐ | ☐ |
| Extremities | ☐ | ☐ |
| Skin | ☐ | ☐ |
| Neurological | ☐ | ☐ |
| Back/spine | ☐ | ☐ |
| Psychosocial Development | ☐ | ☐ |
| Language | ☐ | ☐ |
| 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)** *(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)* | __ __ / __ __ / __ __ | ☐ At risk *(do BLL)* ☐ Not at risk |
| **Hearing** ☐ Pure tone audiometry ☐ OAE | __ __ / __ __ / __ __ | ☐ Normal ☐ 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* | __ __ / __ __ / __ __ | ☐ Neg ☐ Pos |
| Interferon Test | __ __ / __ __ / __ __ | ☐ Neg ☐ Pos |
| Chest x-ray *(if PPD or Interferon positive)* | __ __ / __ __ / __ __ | ☐ NI ☐ Abnl ☐ Not Indicated |
| **Vision** *(required for new school entrants and children age 4–7 yrs)* | __ __ / __ __ / __ __ ☐ with glasses | Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ 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 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