

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="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 Last Name	<input type="checkbox"/> Foster Parent 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 _____	Does the child/adolescent have a past or present medical history of the following? 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)
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) _____	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: <table border="1"><tr><td><i>Ni Abnl</i></td><td><input type="checkbox"/> HEENT</td><td><i>Ni Abnl</i></td><td><input type="checkbox"/> Lymph nodes</td><td><i>Ni Abnl</i></td><td><input type="checkbox"/> Abdomen</td><td><i>Ni Abnl</i></td><td><input type="checkbox"/> Skin</td><td><i>Ni Abnl</i></td><td><input type="checkbox"/> Psychosocial Development</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/> DENTAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Language</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Behavioral</td></tr></table> Describe abnormalities:	<i>Ni Abnl</i>	<input type="checkbox"/> HEENT	<i>Ni Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Ni Abnl</i>	<input type="checkbox"/> Abdomen	<i>Ni Abnl</i>	<input type="checkbox"/> Skin	<i>Ni Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
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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 <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) _____/_____/_____ _____ µg/dL</td><td></td><td></td></tr><tr><td>Lead Risk Assessment (annually, age 6 mo-6 yrs) _____/_____/_____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td><td></td><td></td></tr><tr><td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE _____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td><td></td><td></td></tr><tr><td>Hemoglobin or Hematocrit (age 9-12 mo) _____/_____/_____ _____ g/dL _____ %</td><td>Head Start Only</td><td></td></tr></tbody></table>		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="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 PPD/Mantoux placed _____/_____/_____ Duration _____ 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 (if PPD or Interferon positive) _____/_____/_____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl Vision (required for new school entrants and children age 4-7 yrs) _____/_____/_____ <input type="checkbox"/> with glasses Acuity Right ____/____ Left ____/____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
	Date Done	Results															
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IMMUNIZATIONS - DATES CIR Number of Child _____ <table border="1"><tr><td>Hep B</td><td>____/____/____</td></tr><tr><td>Rotavirus</td><td>____/____/____</td></tr><tr><td>DTP/DTaP/DT</td><td>____/____/____</td></tr><tr><td>Hib</td><td>____/____/____</td></tr><tr><td>PCV</td><td>____/____/____</td></tr><tr><td>Polio</td><td>____/____/____</td></tr></table>	Hep B	____/____/____	Rotavirus	____/____/____	DTP/DTaP/DT	____/____/____	Hib	____/____/____	PCV	____/____/____	Polio	____/____/____	Influenza _____/_____/_____ MMR _____/_____/_____ Varicella _____/_____/_____ Td _____/_____/_____ Tdap _____/_____/_____ Hep A _____/_____/_____ Meningococcal _____/_____/_____ HPV _____/_____/_____ Other, Specify: _____; _____; _____
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Rotavirus	____/____/____												
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Hib	____/____/____												
PCV	____/____/____												
Polio	____/____/____												

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 PROVIDER 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 _____ State _____ Zip _____	Date Reviewed: ____/____/____
Telephone (____) _____ - _____	Fax (____) _____ - _____	I.D. NUMBER _____ REVIEWER: _____