

# 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 <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 <input type="checkbox"/> Yes (including Medicaid)? <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)

<b>Birth history</b> (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <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) _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> 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) _____		<b>Medications</b> (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____	
Explain all checked items above or on addendum					

### PHYSICAL EXAMINATION

Height \_\_\_\_\_ cm (\_\_\_\_ %ile)  
 Weight \_\_\_\_\_ kg (\_\_\_\_ %ile)  
 BMI \_\_\_\_\_ kg/m<sup>2</sup> (\_\_\_\_ %ile)  
 Head Circumference (age ≤2 yrs) \_\_\_\_\_ cm (\_\_\_\_ %ile)  
 Blood Pressure (age ≥3 yrs) \_\_\_\_\_ / \_\_\_\_\_

### General Appearance:

NI Abnl	HEENT	NI Abnl	Lymph nodes	NI Abnl	Abdomen	NI Abnl	Skin	NI Abnl	Psychosocial Development
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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

### Describe abnormalities:

<b>DEVELOPMENTAL</b> (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 _____	<b>SCREENING TESTS</b>		<b>Date Done</b>		<b>Results</b>		
	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)		____/____/____		_____ µg/dL		
	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)		____/____/____		<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		
	<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE		____/____/____		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
<b>Hemoglobin or Hematocrit</b> (age 9-12 mo)		<b>Head Start Only</b>		____/____/____		_____ g/dL _____ %	
<b>Tuberculosis</b> Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school		<b>Date Done</b>		<b>Results</b>		<b>Results</b>	
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 (if PPD or Interferon positive)		____/____/____		<input type="checkbox"/> NI <input type="checkbox"/> Not <input type="checkbox"/> Abnl Indicated		_____	
<b>Vision</b> (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		_____	

### IMMUNIZATIONS - DATES

CIR Number  
of Child

--	--	--	--	--	--	--	--

Hep B \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Rotavirus \_\_\_\_/\_\_\_\_/\_\_\_\_  
 DTP/DTaP/DT \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Hib \_\_\_\_/\_\_\_\_/\_\_\_\_  
 PCV \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Polio \_\_\_\_/\_\_\_\_/\_\_\_\_

Influenza \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MMR \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Varicella \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Td \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Tdap \_\_\_\_/\_\_\_\_/\_\_\_\_  
 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: