

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	Parent/Guardian Last Name		First Name		
	Foster Parent <input type="checkbox"/>				

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? <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) _____	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/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><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td></tr><tr><td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</td><td><input type="checkbox"/> Skin</td><td><input type="checkbox"/> Psychosocial Development</td></tr><tr><td><input type="checkbox"/> Dental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/> Language</td></tr><tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/> Behavioral</td></tr></table> Describe abnormalities: _____	<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
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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) <i>(required at age 1 yr and 2 yrs and for those at risk)</i></td><td>___/___/___</td><td>_____ µg/dL</td></tr><tr><td>Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i></td><td>___/___/___</td><td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td></tr><tr><td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td><td>___/___/___</td><td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td></tr><tr><td>Hemoglobin or Hematocrit (age 9-12 mo)</td><td>___/___/___</td><td>_____ g/dL _____ %</td></tr></tbody></table>		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 _____ %	<table border="1"><thead><tr><th></th><th>Date Done</th><th>Results</th></tr></thead><tbody><tr><td>Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i></td><td>___/___/___</td><td>Induration _____ mm</td></tr><tr><td>PPD/Mantoux placed</td><td>___/___/___</td><td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td></tr><tr><td>PPD/Mantoux read</td><td>___/___/___</td><td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td></tr><tr><td>Interferon Test</td><td>___/___/___</td><td><input type="checkbox"/> NI <input type="checkbox"/> Not Indicated</td></tr><tr><td>Chest x-ray <i>(if PPD or interferon positive)</i></td><td>___/___/___</td><td><input type="checkbox"/> NI <input type="checkbox"/> Not Indicated</td></tr><tr><td>Vision <i>(required for new school entrants and children age 4-7 yrs)</i></td><td>___/___/___</td><td>Acuity Right ___/___ Left ___/___ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes</td></tr></tbody></table>		Date Done	Results	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i>	___/___/___	Induration _____ mm	PPD/Mantoux placed	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	PPD/Mantoux read	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	Interferon Test	___/___/___	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated	Chest x-ray <i>(if PPD or interferon positive)</i>	___/___/___	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated	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
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IMMUNIZATIONS - DATES CIR Number of Child _____ Hep B _____ DTP/DTaP/DT _____ PCV _____ Other, Specify: _____	MMR _____ Td _____ Meningococcal _____
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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
Health Care Provider Name and Degree (print) _____	Provider License No. and State _____	TYPE OF EXAM: <input type="checkbox"/> Well Exam <input type="checkbox"/> Well Exam with Problem <input type="checkbox"/> Problem Focused
Facility Name _____	National Provider Identifier (NPI) _____	DATE: ___/___/___
Address _____	City _____ State _____ Zip _____	REMEMBER: _____
Telephone (_____) _____	Fax (_____) _____	