

# 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 _____ Call _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name	
	Foster Parent			

## TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

<b>Birth history (age 0-6 yrs)</b> <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 (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
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Explain all checked items above or on addendum

<b>PHYSICAL EXAMINATION</b> 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) _____ / _____	<b>General Appearance:</b> <table border="0"> <tr> <td>NI Abnl</td><td>HEENT</td><td>NI Abnl</td><td>Lymph nodes</td><td>NI Abnl</td><td>Abdomen</td><td>NI Abnl</td><td>Skin</td><td>NI Abnl</td><td>Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td><td>Dental</td><td><input type="checkbox"/></td><td>Lungs</td><td><input type="checkbox"/></td><td>Genitourinary</td><td><input type="checkbox"/></td><td>Neurological</td><td><input type="checkbox"/></td><td>Language</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td><td>Neck</td><td><input type="checkbox"/></td><td>Cardiovascular</td><td><input type="checkbox"/></td><td>Extremities</td><td><input type="checkbox"/></td><td>Back/spine</td><td><input type="checkbox"/></td><td>Behavioral</td> </tr> </table> <b>Describe abnormalities:</b> _____	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"/>	Dental	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	Language	<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"/>	Neck	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	Back/spine	<input type="checkbox"/>	Behavioral
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<b>DEVELOPMENTAL (age 0-6 yrs)</b> <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> <table border="1"> <thead> <tr> <th>Test</th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td><b>Blood Lead Level (BLL)</b> <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><b>Lead Risk Assessment</b> <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><b>Hearing</b> <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><b>Hemoglobin or Hematocrit</b> <i>(age 9-12 mo)</i></td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>	Test	Date Done	Results	<b>Blood Lead Level (BLL)</b> <i>(required at age 1 yr and 2 yrs and for those at risk)</i>	____/____/____	____ µg/dL	<b>Lead Risk Assessment</b> <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<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> <i>(age 9-12 mo)</i>	____/____/____	____ g/dL ____ %	<b>Tuberculosis</b> <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> 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 <b>Vision</b> <i>(required for new school entrants and children age 4-7 yrs)</i> <input type="checkbox"/> with glasses Acuity Right ____/____ Left ____/____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
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<b>IMMUNIZATIONS - DATES</b> CIR Number of Child _____ Hep B _____ Rotavirus _____ DTP/DTaP/DT _____ Hib _____ PCV _____ Polio _____	Influenza _____ MMR _____ Varicella _____ Td _____ Tdap _____ Hep A _____ Meningococcal _____ HPV _____ Other, Specify: _____
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<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <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 _____	<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ <b>ICD-9 Code</b> _____
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Health Care Provider Signature	Date	DOHMH PROVIDER ONLY 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
Telephone	Fax	Date Reviewed: _____ I.D. NUMBER _____
		REVIEWER: _____