

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 (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name	
	<input type="checkbox"/> Foster Parent			

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 <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"/> If persistent, check all current medication(s): <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)
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Explain all checked items above or on addendum

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 <input type="checkbox"/> HEENT <input type="checkbox"/> Dental <input type="checkbox"/> Neck	NI Abnl <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Lungs <input type="checkbox"/> Cardiovascular	NI Abnl <input type="checkbox"/> Abdomen <input type="checkbox"/> Genitourinary <input type="checkbox"/> Extremities	NI Abnl <input type="checkbox"/> Skin <input type="checkbox"/> Neurological <input type="checkbox"/> Back/spine	NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Language <input type="checkbox"/> Behavioral
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Describe abnormalities:

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>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)</td> <td>_____ µg/dL _____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</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>_____ / _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>_____ g/dL _____ %</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 _____ 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 _____ %	<table border="1"> <thead> <tr> <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> </tr> <tr> <td>PPD/Mantoux placed</td> <td>_____ / _____ Induration _____ mm</td> </tr> <tr> <td>PPD/Mantoux read</td> <td>_____ / _____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos</td> </tr> <tr> <td>Interferon Test</td> <td>_____ / _____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos</td> </tr> <tr> <td>Chest x-ray (if PPD or Interferon positive)</td> <td>_____ / _____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl</td> </tr> <tr> <td>Vision (required for new school entrants and children age 4-7 yrs)</td> <td>_____ / _____ <input type="checkbox"/> with glasses Acuity Right ___ / ___ Left ___ / ___ 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>		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 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
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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	DOHMH 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	Date Reviewed: _____ / _____ / _____
Telephone (_____) _____	Fax (_____) _____	REVIEWER: _____