CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number | Phone Numbers: Home / Cell / Work

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status: ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis ☐ Behavioral/mental health disorder ☐ Congenital or acquired heart disorder ☐ Developmental/learning problem ☐ Diabetes (attach MAF) ☐ Orthopedic injury/disability

☐ Seizure disorder ☐ Speech, hearing, or visual impairment ☐ Tuberculosis (latent infection or disease) ☐ Hospitalization ☐ Surgery ☐ Other (specify) _____

Explain all checked items above. ☐ ***Addendum attached.***

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

☐ Physical Exam WNL

NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐ Abdomen	☐	☐	Skin
☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐ Genitourinary	☐	☐	Neurological
☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐ Extremities	☐	☐	Back/spine

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help ☐ Communication/Language ☐ Gross Motor/Fine Motor ☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

SCREENING TESTS	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)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral (pain, swelling, infection) ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems (list) — ICD-10 Code

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___ | DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree (print) | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

FORM ID#