

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 <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 _____
Health insurance <input type="checkbox"/> Yes <input type="checkbox"/> No (including Medicaid)? <input type="checkbox"/> No			Parent/Guardian Last Name	First Name
			Email	
			Phone Numbers Home _____ Cell _____ Work _____	

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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): If persistent, check all current medication(s): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Asthma Control Status _____ <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
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PHYSICAL EXAM Date of Exam: ____/____/____ 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: <input type="checkbox"/> Physical Exam WNL <table border="0"> <tr> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> </tr> <tr> <td><input type="checkbox"/> Psychosocial Development</td> <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> </tr> <tr> <td><input type="checkbox"/> Language</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> </tr> <tr> <td><input type="checkbox"/> Behavioral</td> <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> </tr> </table>	NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI Abnl	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
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DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____	Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)	Hearing Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred
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SCREENING TESTS Date Done Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	VISION Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right _____/_____ Left _____/_____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Describe Suspected Delay or Concern: _____ Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Care Only Hemoglobin or Hematocrit ____/____/____ _____ g/dL _____ %	Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No
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CIR Number _____ Physician Confirmed History of Varicella Infection <input type="checkbox"/>	Report only positive immunity:																																				
IMMUNIZATIONS – DATES	<table border="0"> <tr> <td>OTIP/DTaP/DT</td> <td>Tdap</td> <td>IgG Titers</td> <td>Date</td> </tr> <tr> <td>Td</td> <td>MMR</td> <td>Hepatitis B</td> <td>____/____/____</td> </tr> <tr> <td>Polio</td> <td>Varicella</td> <td>Measles</td> <td>____/____/____</td> </tr> <tr> <td>Hep B</td> <td>Mening ACWY</td> <td>Mumps</td> <td>____/____/____</td> </tr> <tr> <td>Hib</td> <td>Hep A</td> <td>Rubella</td> <td>____/____/____</td> </tr> <tr> <td>PCV</td> <td>Rotavirus</td> <td>Varicella</td> <td>____/____/____</td> </tr> <tr> <td>Influenza</td> <td>Mening B</td> <td>Polio 1</td> <td>____/____/____</td> </tr> <tr> <td>HPV</td> <td>Other</td> <td>Polio 2</td> <td>____/____/____</td> </tr> <tr> <td></td> <td></td> <td>Polio 3</td> <td>____/____/____</td> </tr> </table>	OTIP/DTaP/DT	Tdap	IgG Titers	Date	Td	MMR	Hepatitis B	____/____/____	Polio	Varicella	Measles	____/____/____	Hep B	Mening ACWY	Mumps	____/____/____	Hib	Hep A	Rubella	____/____/____	PCV	Rotavirus	Varicella	____/____/____	Influenza	Mening B	Polio 1	____/____/____	HPV	Other	Polio 2	____/____/____			Polio 3	____/____/____
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ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <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"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature	Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ I.D. NUMBER _____
Address	City State Zip	REVIEWER _____