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 ____

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

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

Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl	Nl 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	__/__/__	☐ Nl ☐ Abnl ☐ Referred
OAE	__/__/__	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	__/__/__	☐ Nl ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	__/__/__	☐ Nl ☐ 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 ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
Td	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Polio	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Hep B	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Hib	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
PCV	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
Influenza	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	
HPV	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	

Tdap	_/_/_	_/_/_	_/_/_
MMR	_/_/_	_/_/_	_/_/_
Varicella	_/_/_	_/_/_	_/_/_
Mening ACWY	_/_/_	_/_/_	_/_/_
Hep A	_/_/_	_/_/_	_/_/_
Rotavirus	_/_/_	_/_/_	_/_/_
Mening B	_/_/_	_/_/_	_/_/_
Other ____	_/_/_	_/_/_	

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		**TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) Comments:
Facility Name	National Provider Identifier (NPI)		Date Reviewed: __/__/__ — **I.D. NUMBER**
Address	City	State Zip	REVIEWER:
Telephone	Fax	Email	**FORM ID#**