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** ☐ 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** Last Name | First Name | ☐ **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)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

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

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ 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)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

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
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

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 __ __ / __ __ / __ __

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

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

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -

CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

CENTER

NAME:

ADDRESS:

BORO:

318K (REV. 4/12)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____ /____ / _____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)			SEX F ❑ M ❑	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro)			(State)	(Zip)
MOTHER'S NAME: (First) (Last)	FATHER'S NAME: (First) (Last)			TELEPHONE NO Home: Work:
FOSTER PARENT				
FOSTER AGENCY	ADDRESS		TELEPHONE #	
LANGUAGE SPOKEN IN HOME				

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*		
NAME	RELATIONSHIP TO CHILD	
ADDRESS		TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(_____) Asthma	(_____) Heart Disease	(_____) Medications *(Specify)*
(_____) Diabetes	(_____) Hypertension	(_____) None _____
(_____) Convulsive Disorder	(_____) Tuberculosis	(_____) Foods *(Specify)* _____
(_____) Allergies *(Specify)*	(_____) Vision	(_____) Insect Bites _____
(_____) OTHER *(Specify)*	(_____) Hearing	(_____) OTHER _____

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS	AGE IT BEGAN	TREATMENT/MEDICATIONS
(Long term or chronic)		
1. _____		
2. _____		
3. _____		
4. _____		
5.		

I,_____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

_____ _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

AUTHORIZED PICK UP FORM

Family Day Care and Group Family Day Care

The following persons are authorized by parent/ guardian to pick up my child (child's name) _____ from_____ and must show proper ID.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please notify us if there is a need to have your child picked up by a person other than the individual's listed above. We will not allow your child to be picked up without your authorization.

Parent/Guardian Signature:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

CHANGING DIAPER CONSENT FORM

Family Day Care and Group Family Day Care

I, (parent name) _____ , authorize _____ to change my child's diaper and put on an over the counter topical ointment as needed.

Make sure you bring diapers, wipes, and pullups if the child is toilet training. It is your responsibility to bring these supplies on a weekly basis. We are not accepting children in the program without these supplies. Please make sure to write the name of your child on the ointment to be used.
of the child care home.

Child Care Provider:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

Parent/Guardian:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

FIELD TRIP PERMISSION FORM

Family Day Care and Group Family Day Care

I authorize, (provider nam name) _____ , and their employees permission to take my child _____ for short trips as part of their family day care program.

Child Care Provider:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

Parent/Guardian:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

Address: _____

State, City, Zip Code: _____

SLEEPING AND NAPPING AGREEMENT

Family Day Care and Group Family Day Care

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7 (i) and 417.8 (a) (1), and Group Family Day Care 416.7 (i) and 416.8 (a) (1)].

I, (parent name) _____ , understand that my child(ren), _____, while under the care of (child care provider) _____, will be napping on a (bed/cot/mat/chair) _____ in the (baby room/main room)_____ of the child care home.

My napping child will have competent supervision at all times, either through: (Please check one box below)

□ Direct supervision by a caregiver who is in the same room and has direct visual contact with him/her;

OR

□ Indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as the doors to all rooms used by the provider.

If my child is an infant, I also understand that my child will be placed on his/her back to sleep.

Child Care Provider:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

Parent/Guardian:

Name (please print): _____

Signature: _____

Date (Month/Day/Year): _____

PERMISSION FOR OUTDOOR ACTIVITIES

The provider _____

and staff of _____

may take my child _____

for short walking trips and any of the activities checked below as part of the Group Family/ Family Day Care program.

___ Provider's Backyard

___ Neighborhood Park

Parent's Signature:

_____

Address:

_____

_____

Telephone #: _____

Date: _____