

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

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|---|------------|-------------|---|---|
| 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 |
| | | | <input type="checkbox"/> Parent/Guardian | <input type="checkbox"/> Foster Parent |
| | | | | Phone Numbers Home _____ Cell _____ Work _____ |

TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

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

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| PHYSICAL EXAMINATION 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: <table border="0"> <tr> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> Lymph nodes</td> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> Skin</td> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Back/spine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____ | <input type="checkbox"/> NI Abnl | <input type="checkbox"/> HEENT | <input type="checkbox"/> NI Abnl | <input type="checkbox"/> Lymph nodes | <input type="checkbox"/> NI Abnl | <input type="checkbox"/> Abdomen | <input type="checkbox"/> NI Abnl | <input type="checkbox"/> Skin | <input type="checkbox"/> NI Abnl | <input type="checkbox"/> Psychosocial Development | <input type="checkbox"/> | <input type="checkbox"/> Dental | <input type="checkbox"/> | <input type="checkbox"/> Lungs | <input type="checkbox"/> | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> Neurological | <input type="checkbox"/> | <input type="checkbox"/> Language | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> Extremities | <input type="checkbox"/> | <input type="checkbox"/> Back/spine | <input type="checkbox"/> | <input type="checkbox"/> Behavioral |
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| DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits 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>Test</th> <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>____/____/____</td> <td>____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td> <td>____/____/____</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>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td colspan="3" style="text-align: center;">Head Start Only</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table> | Test | 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 | Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE | ____/____/____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Head Start Only | | | Hemoglobin or Hematocrit (age 9-12 mo) | ____/____/____ | ____ g/dL ____ % | Tuberculosis <small>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</small> 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 <input type="checkbox"/> Indicated 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 |
|---|---|---|-----------|---------|---|----------------|------------|---|----------------|---|---|----------------|--|------------------------|--|--|---|----------------|---------------------|--|
| Test | Date Done | Results | | | | | | | | | | | | | | | | | | |
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| Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE | ____/____/____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | | | | | | | | | | | | | | | | | | |
| Head Start Only | | | | | | | | | | | | | | | | | | | | |
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| IMMUNIZATIONS - DATES CIR Number of Child _____ <table border="0"> <tr><td>Hep B</td><td>____/____/____</td></tr> <tr><td>Rotavirus</td><td>____/____/____</td></tr> <tr><td>DTP/DTaP/DT</td><td>____/____/____</td></tr> <tr><td>Hib</td><td>____/____/____</td></tr> <tr><td>PCV</td><td>____/____/____</td></tr> <tr><td>Polio</td><td>____/____/____</td></tr> </table> | Hep B | ____/____/____ | Rotavirus | ____/____/____ | DTP/DTaP/DT | ____/____/____ | Hib | ____/____/____ | PCV | ____/____/____ | Polio | ____/____/____ | Influenza _____ MMR _____ Varicella _____ Td _____ Tdap _____ Hep A _____ Meningococcal _____ HPV _____ Other, specify: _____ |
| Hep B | ____/____/____ | | | | | | | | | | | | |
| Rotavirus | ____/____/____ | | | | | | | | | | | | |
| DTP/DTaP/DT | ____/____/____ | | | | | | | | | | | | |
| Hib | ____/____/____ | | | | | | | | | | | | |
| PCV | ____/____/____ | | | | | | | | | | | | |
| Polio | ____/____/____ | | | | | | | | | | | | |

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| RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <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"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____ | ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ |
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| 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 Years |
| Facility Name | National Provider Identifier (NPI) | Comments |
| Address | City | State |
| Telephone (____) _____ | Fax (____) _____ | Date Reviewed: _____ |
| | | REVIEWER: _____ |