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
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ___
☐ *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
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-5 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 ☐

IMMUNIZATIONS – DATES

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

Tdap	___/___/___	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___	___/___/___
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 ___/___/___

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

DOHMH ONLY PRACTITIONER I.D. ☐☐☐☐☐☐☐

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

Comments:

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

REVIEWER:

FORM ID#: ☐☐☐☐☐☐☐☐☐