

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

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) _____ Attach MAF in in-school medications needed		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (attach severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medications: <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 Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <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)	

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 NI Abnl <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Language <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck				
		Describe abnormalities:				

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	
Describe Suspected Delay or Concern: _____ Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		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) ____/____/____ <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	
		Hematoglobin or Hematocrit ____/____/____ g/dL % _____ Child Care Only _____		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	

CIR Number _____		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
IMMUNIZATIONS - DATES DTaP/DTaP/DT _____ Tdap _____ Td _____ MMR _____ Polio _____ Varicella _____ Hep B _____ Mening ACWY _____ Hib _____ Hep A _____ PCV _____ Rotavirus _____ Influenza _____ Mening B _____ HPV _____ Other <u>COVID</u> _____				Hepatitis B _____ Measles _____ Mumps _____ Rubella _____ Varicella _____ Polio 1 _____ Polio 2 _____ Polio 3 _____	

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 PRACTITIONER ONLY 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)
Facility Name		National Provider Identifier (NPI)	Comments:
Address		City State Zip	Date Reviewed: ____/____/____ I.D. NUMBER _____
Telephone	Fax	Email	REVIEWER: _____
			FORM ID# _____