

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

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

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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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): <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"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> 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) | |
| Attach MAF if in-school medications needed | | | | | |

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| 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"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine | | Describe abnormalities: | |
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|---|--|--|--|--|--|
| 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: _____ Describe Suspected Delay or 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 | |
| | | 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 | |
| Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No | | Hemoglobin or Hematocrit ____/____/____ ____ g/dL ____% | | 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 | |

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

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