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 ________

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name**	**First Name**	**Email**

Cell ________
Work ________

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? Date Screened

☐ Yes ☐ No ____/____/____

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 ☐ Report only positive immunity:

IMMUNIZATIONS – DATES

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

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

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# ☐☐☐☐☐☐☐☐☐☐