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 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
- ☐ Seizure disorder
- ☐ Speech, hearing, or visual impairment
- ☐ Tuberculosis *(latent infection or disease)*
- ☐ Hospitalization
- ☐ Surgery
- ☐ Other (specify) ______

Explain all checked items above. ☐ ***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 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No | Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

- ☐ Cognitive/Problem Solving
- ☐ Communication/Language
- ☐ Social-Emotional or Personal-Social
- ☐ Adaptive/Self-Help
- ☐ Gross Motor/Fine Motor
- ☐ 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

Vaccine	Dates
DTP/DTaP/DT	___/___/___ (×6)
Td	___/___/___ (×5)
Polio	___/___/___ (×5)
Hep B	___/___/___ (×5)
Hib	___/___/___ (×5)
PCV	___/___/___ (×5)
Influenza	___/___/___ (×5)
HPV	___/___/___ (×5)
Tdap	___/___/___ (×2)
MMR	___/___/___ (×3)
Varicella	___/___/___ (×3)
Mening ACWY	___/___/___ (×3)
Hep A	___/___/___ (×3)
Rotavirus	___/___/___ (×3)
Mening B	___/___/___ (×3)
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#