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	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? ☐ 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 ☐ 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 ___/___/___ | **DOHMH ONLY** **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) *Comments:*

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip | Date Reviewed: ___/___/___ **I.D. NUMBER** REVIEWER:

Telephone | Fax | Email | **FORM ID#**