# 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 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? 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#** ☐☐☐☐☐☐☐☐☐☐