

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 <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 <input type="checkbox"/> No (including Medicaid)? <input type="checkbox"/> No		Parent/Guardian Last Name		First Name		Email		
		Foster Parent						

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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) _____ Attach MAF in in-school medications needed		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status _____ <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above. <input type="checkbox"/> Addendum attached.		<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <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"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)																													
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 <table border="0"> <tr> <td>NI Abnl</td> <td><input type="checkbox"/> Psychosocial Development</td> <td>NI Abnl</td> <td><input type="checkbox"/> HEENT</td> <td>NI Abnl</td> <td><input type="checkbox"/> Lymph nodes</td> <td>NI Abnl</td> <td><input type="checkbox"/> Abdomen</td> <td>NI Abnl</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Language</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Back/spine</td> </tr> <tr> <td><input type="checkbox"/> Behavioral</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/> Extremities</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				NI Abnl	<input type="checkbox"/> Psychosocial Development	NI Abnl	<input type="checkbox"/> HEENT	NI Abnl	<input type="checkbox"/> Lymph nodes	NI Abnl	<input type="checkbox"/> Abdomen	NI Abnl	<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"/> Back/spine	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities					
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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) ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ 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 CIR Number _____		Child Care Only 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																													

IMMUNIZATIONS – DATES DTP/DTaP/DT _____ Tdap _____ Td _____ MMR _____ Polio _____ Varicella _____ Hep B _____ Mening ACWY _____ Hib _____ Hep A _____ PCV _____ Rotavirus _____ Influenza _____ Mening B _____ HPV _____ Other _____		Report only positive immunity: IgG Titers Date 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)	
Facility Name		National Provider Identifier (NPI)		Comments:	
Address		City		State	
Telephone		Fax		Email	
				Date Reviewed: ____/____/____ I.D. NUMBER _____	
				REVIEWER: _____	
				FORM ID# _____	