

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 (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Email		
<input type="checkbox"/> 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 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): If persistent, check all current medication(s): Asthma Control Status <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"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached. Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
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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="1"><tr><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td><td><i>Ni Abnl</i></td></tr><tr><td><input type="checkbox"/> Psychosocial Development</td><td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</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></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><input type="checkbox"/> Back/spine</td></tr></table> Describe abnormalities:	<i>Ni Abnl</i>	<i>Ni Abnl</i>	<i>Ni Abnl</i>	<i>Ni Abnl</i>	<i>Ni Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<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"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
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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: _____ Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	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) SCREENING TESTS <table border="1"><thead><tr><th>Test</th><th>Date Done</th><th>Results</th></tr></thead><tbody><tr><td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td><td>____/____/____</td><td>____ µg/dL</td></tr><tr><td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td><td>____/____/____</td><td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td></tr><tr><td colspan="3" style="text-align: center;">— Child Care Only —</td></tr><tr><td>Hemoglobin or Hematocrit</td><td>____/____/____</td><td>____ g/dL _____ %</td></tr></tbody></table>	Test	Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ µg/dL	Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	— Child Care Only —			Hemoglobin or Hematocrit	____/____/____	____ g/dL _____ %	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 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 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
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IMMUNIZATIONS - DATES CIR Number _____ Physician Confirmed History of Varicella Infection <input type="checkbox"/> Report only positive immunity: <table border="1"><thead><tr><th>IG Titers</th><th>Date</th></tr></thead><tbody><tr><td>Hepatitis B</td><td>____/____/____</td></tr><tr><td>Measles</td><td>____/____/____</td></tr><tr><td>Mumps</td><td>____/____/____</td></tr><tr><td>Rubella</td><td>____/____/____</td></tr><tr><td>Varicella</td><td>____/____/____</td></tr><tr><td>Polio 1</td><td>____/____/____</td></tr><tr><td>Polio 2</td><td>____/____/____</td></tr><tr><td>Polio 3</td><td>____/____/____</td></tr></tbody></table>	IG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____	<table border="1"><thead><tr><th>Immunization</th><th>Date</th></tr></thead><tbody><tr><td>DTP/DTaP/DT</td><td>____/____/____</td></tr><tr><td>Td</td><td>____/____/____</td></tr><tr><td>Polio</td><td>____/____/____</td></tr><tr><td>Hep B</td><td>____/____/____</td></tr><tr><td>Hib</td><td>____/____/____</td></tr><tr><td>PCV</td><td>____/____/____</td></tr><tr><td>Influenza</td><td>____/____/____</td></tr><tr><td>HPV</td><td>____/____/____</td></tr><tr><td>Tdap</td><td>____/____/____</td></tr><tr><td>MMR</td><td>____/____/____</td></tr><tr><td>Varicella</td><td>____/____/____</td></tr><tr><td>Mening ACWY</td><td>____/____/____</td></tr><tr><td>Hep A</td><td>____/____/____</td></tr><tr><td>Rotavirus</td><td>____/____/____</td></tr><tr><td>Mening B</td><td>____/____/____</td></tr><tr><td>Other</td><td>____/____/____</td></tr></tbody></table>	Immunization	Date	DTP/DTaP/DT	____/____/____	Td	____/____/____	Polio	____/____/____	Hep B	____/____/____	Hib	____/____/____	PCV	____/____/____	Influenza	____/____/____	HPV	____/____/____	Tdap	____/____/____	MMR	____/____/____	Varicella	____/____/____	Mening ACWY	____/____/____	Hep A	____/____/____	Rotavirus	____/____/____	Mening B	____/____/____	Other	____/____/____
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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) Comments: _____
Facility Name _____ National Provider Identifier (NPI) _____	Date Reviewed: ____/____/____ I.D. NUMBER _____
Address _____ City _____ State _____ Zip _____	REVIEWER: _____
Telephone _____ Fax _____ Email _____	FORM ID# _____