CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY 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

TO BE COMPLETED BY HEALTH CARE PROVIDER — If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs)
☐ Uncomplicated ☐ Premature: _______ weeks gestation
☐ Complicated by

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs (list)
☐ Foods (list)
☐ Other (list)

Does the child/adolescent have a past or present medical history of the following?
☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None
☐ Attention Deficit Hyperactivity Disorder ☐ Orthopedic injury/disability
☐ Chronic or recurrent otitis media ☐ Seizure disorder
☐ Congenital or acquired heart disorder ☐ Speech, hearing, or visual impairment
☐ Developmental/learning problem ☐ Tuberculosis (latent infection or disease)
☐ Diabetes (attach MAF) ☐ Other (specify)

Explain all checked items above or on addendum

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)

Dietary Restrictions ☐ None ☐ Yes (list below)

PHYSICAL EXAMINATION

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:

Nl Abnl		Nl Abnl		Nl Abnl		Nl Abnl		Nl Abnl	
☐ ☐	HEENT	☐ ☐	Lymph nodes	☐ ☐	Abdomen	☐ ☐	Skin	☐ ☐	Psychosocial Development
☐ ☐	Dental	☐ ☐	Lungs	☐ ☐	Genitourinary	☐ ☐	Neurological	☐ ☐	Language
☐ ☐	Neck	☐ ☐	Cardiovascular	☐ ☐	Extremities	☐ ☐	Back/spine	☐ ☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits
If delay suspected, specify below
☐ Cognitive (e.g., play skills)
☐ Communication/Language
☐ Social/Emotional
☐ Adaptive/Self-Help
☐ Motor

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
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit (age 9–12 mo)	__/__/__	____ g/dL ____ %

	Date Done	Results
Tuberculosis — Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school		
PPD/Mantoux placed	__/__/__	Induration ____ mm
PPD/Mantoux read	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray (if PPD or interferon positive)	__/__/__	☐ Nl ☐ Abnl ☐ Not indicated
Vision (required for new school entrants and children age 4–7 yrs)	__/__/__ ☐ with glasses	Acuity Right __/__ Left __/__ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B
Rotavirus
DTP/DTaP/DT
Hib
PCV
Polio
Influenza
MMR
Varicella
Td
Tdap
Hep A
Meningococcal
HPV
Other, specify:

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions (specify)
Follow-up Needed ☐ No ☐ Yes, for ________ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems (list) | ICD-9 Code

Health Care Provider Signature | Date __/__/__ | DOHMH ONLY PROVIDER I.D.

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

Facility Name | National Provider Identifier (NPI) | Comments

Address | City | State | Zip | Date Reviewed: __/__/__ | I.D. NUMBER

Telephone ( ) | Fax ( ) | REVIEWER:

CH-205 (5/09)

Copies: White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian