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 Last Name First Name | Foster Parent

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 corticosteriod Other controller Quick relief med Oral steroid None

Attention Deficit Hyperactivity Disorder
Chronic or recurrent otitis media
Congenital or acquired heart disorder
Developmental/learning problem
Diabetes (attach MAF)
Orthopedic injury/disability
Seizure disorder
Speech, hearing, or visual impairment
Tuberculosis (latent infection or disease)
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/m² (___ %ile)

Head Circumference (age ≤2 yrs) ___ cm (___ %ile)

Blood Pressure (age ≥3 yrs) ___ / ___

General Appearance:

NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI 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)	___/___/___	NI Not Abnl 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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone ( ) – | Fax ( ) –

TYPE OF EXAM: NAE Current NAE Prior Year(s)

Comments

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

CH-205 (5/08) **Copies**: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian