# 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 | Cell | Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

## 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
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
***Explain all checked items above.***
☐ ***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? ☐ Yes ☐ No — Date Screened ___/___/___

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 ☐

**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 | | ___/___/___ |

**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 ___/___/___

**DOHMH ONLY** PRACTITIONER I.D.

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

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

*Comments:*

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

REVIEWER:

FORM ID#