Return By June 1st.

# 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 |
|---|---|---|
| Psychosocial Development | ☐ | ☐ |
| Language | ☐ | ☐ |
| Behavioral | ☐ | ☐ |
| HEENT | ☐ | ☐ |
| Dental | ☐ | ☐ |
| Neck | ☐ | ☐ |
| Lymph nodes | ☐ | ☐ |
| Lungs | ☐ | ☐ |
| Cardiovascular | ☐ | ☐ |
| Abdomen | ☐ | ☐ |
| Genitourinary | ☐ | ☐ |
| Extremities | ☐ | ☐ |
| Skin | ☐ | ☐ |
| Neurological | ☐ | ☐ |
| 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 ☐

Report only positive immunity:

**IMMUNIZATIONS – DATES**

| | | | | IgG Titers | Date |
|---|---|---|---|---|---|
| DTP/DTaP/DT | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Tdap | ___/___/___ ___/___/___ | Hepatitis B | ___/___/___ |
| Td | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | MMR | ___/___/___ ___/___/___ | Measles | ___/___/___ |
| Polio | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Varicella | ___/___/___ ___/___/___ | Mumps | ___/___/___ |
| Hep B | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Mening ACWY | ___/___/___ ___/___/___ | Rubella | ___/___/___ |
| Hib | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Hep A | ___/___/___ ___/___/___ | Varicella | ___/___/___ |
| PCV | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Rotavirus | ___/___/___ ___/___/___ | Polio 1 | ___/___/___ |
| Influenza | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Mening B | ___/___/___ ___/___/___ | Polio 2 | ___/___/___ |
| HPV | ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ | Other | _____ ___/___/___ _____ ___/___/___ | 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 ___/___/___

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

**DOHMH ONLY**

**PRACTITIONER I.D.**

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

*Comments:*

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

REVIEWER

**FORM ID#**