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** O Female O Male | **Date of Birth** *(Month/Day/Year)* / 2008

Child's Address | **Hispanic/Latino?** O Yes O No | **Race** *(Check ALL that apply)* O American Indian O Asian O Black O White O Native Hawaiian/Pacific Islander O Other ______

City/Borough | State N.Y. | Zip Code | School/Center/Camp Name | District Number ____ | **Phone Numbers** *Home* ____ *Cell* ____ *Work* ____

Health insurance (including Medicaid)? O Yes O No | O **Parent/Guardian** O **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)*

O Uncomplicated O Premature: ________weeks gestation

O Complicated by ____________

Allergies O None O Epi pen prescribed

O Drugs *(list)* ____________

O Foods *(list)* ____________

O Other *(list)* ____________

Does the child/adolescent have a past or present medical history of the following?

O Asthma *(check severity and attach MAF/Asthma Action Plan)*: O Intermittent O Mild Persistent O Moderate Persistent O Severe Persistent

If persistent, check all current medication(s): O Inhaled corticosteroid O Other controller O Quick relief med O Oral steroid O None

O Attention Deficit Hyperactivity Disorder
O Chronic or recurrent otitis media
O Congenital or acquired heart disorder
O Developmental/learning problem
O Diabetes *(attach MAF)*
O Orthopedic injury/disability
O Seizure disorder
O Speech, hearing, or visual impairment
O Tuberculosis *(latent infection or disease)*
O **Other** *(specify)* ____________

Explain all checked items above or on addendum

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

Dietary Restrictions O None O 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	
O	O	HEENT	O	O	Lymph nodes	O	O	Abdomen	O	O	Skin	O	O	Psychosocial Development
O	O	Dental	O	O	Lungs	O	O	Genitourinary	O	O	Neurological	O	O	Language
O	O	Neck	O	O	Cardiovascular	O	O	Extremities	O	O	Back/spine	O	O	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* O Within normal limits

If delay suspected, specify below

O Cognitive *(e.g., play skills)* ____________

O Communication/Language ____________

O Social/Emotional ____________

O Adaptive/Self-Help ____________

O 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)*	__/__/__	O At risk *(do BLL)* O Not at risk
Hearing O Pure tone audiometry O OAE	__/__/__	O Normal O 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*	__/__/__	O Neg O Pos
Interferon Test	__/__/__	O Neg O Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	O Nl O Abnl O Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ O with glasses	Acuity *Right* __ / __ *Left* __ / __ Strabismus O No O 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 O Full physical activity O Full diet

O Restrictions *(specify)*

Follow-up Needed O No O Yes, for ____________ Appt. date: __/__/

Referral(s): O None O Early Intervention O Special Education O Dental O Vision

O Other ____________

ASSESSMENT O **Well Child** (V20.2) O **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)

Comments

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Date Reviewed: __/__/__ | I.D. NUMBER

Telephone (____) ______ – ______ | Fax (____) ______ – ______

REVIEWER:

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