

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address		Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____	
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____ Phone Numbers Home _____ Cell _____ Work _____
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No	<input type="checkbox"/> Parent/Guardian Last Name <input type="checkbox"/> Foster Parent	First Name	Email	

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.	<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached.	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
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PHYSICAL EXAM Date of Exam: ____/____/____	General Appearance: <input type="checkbox"/> Physical Exam WNL <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Language <input type="checkbox"/> Behavioral	<input type="checkbox"/> HEENT <input type="checkbox"/> Dental <input type="checkbox"/> Neck	<input type="checkbox"/> Lymph nodes <input type="checkbox"/> Lungs <input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Abdomen <input type="checkbox"/> Genitourinary <input type="checkbox"/> Extremities	<input type="checkbox"/> Skin <input type="checkbox"/> Neurological <input type="checkbox"/> Back/spine
Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	Describe abnormalities:				

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ Describe Suspected Delay or Concern: _____	Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)	Hearing Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	Vision Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	SCREENING TESTS Date Done ____/____/____ Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) _____ μg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) _____ <input type="checkbox"/> Not at risk Hemoglobin or Hematocrit _____ g/dL _____ %	Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number _____	Physician Confirmed History of Varicella Infection <input type="checkbox"/>	Report only positive immunity:
IMMUNIZATIONS - DATES		
DTP/DTaP/DT _____ Tdap _____	MMR _____	Hepatitis B _____
Td _____	Varicella _____	Measles _____
Polio _____	Mening ACWY _____	Mumps _____
Hep B _____	Hep A _____	Rubella _____
Hib _____	Rotavirus _____	Varicella _____
PCV _____	Mening B _____	Polio 1 _____
Influenza _____	Other _____	Polio 2 _____
HPV _____		Polio 3 _____

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature _____	Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print) _____	Practitioner License No. and State _____	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name _____	National Provider Identifier (NPI) _____	Date Reviewed: ____/____/____ I.D. NUMBER _____
Address _____ City _____ State _____ Zip _____		REVIEWER: _____
Telephone _____ Fax _____ Email _____		FORM ID# _____