

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 ☐ Yes (including Medicaid)? ☐ No					☐ Parent/Guardian Last Name ☐ Foster Parent					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): If persistent, check all current medication(s): Asthma Control Status ☐ Anaphylaxis ☐ Behavioral/mental health disorder ☐ Congenital or acquired heart disorder ☐ Developmental/learning problem ☐ Diabetes (attach MAF) ☐ Orthopedic injury/disability Explain all checked items above. ☐ Intermittent ☐ Quick Relief Medication ☐ Well-controlled ☐ Mild Persistent ☐ Inhaled Corticosteroid ☐ Poorly Controlled or Not Controlled ☐ Seizure disorder ☐ Speech, hearing, or visual impairment ☐ Tuberculosis (latent infection or disease) ☐ Hospitalization ☐ Surgery ☐ Other (specify) _____ Addendum attached. ☐ Moderate Persistent ☐ Severe Persistent ☐ Oral Steroid ☐ Other Controller ☐ None 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/m ² (_____%ile) Head Circumference (age ≤3 yrs) _____ cm (_____%ile) Blood Pressure (age ≥3 yrs) _____ / _____										General Appearance: ☐ Physical Exam WNL NI 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? _____ Date Screened ____/____/____ ☐ Yes ☐ No 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:										Nutrition < 1 year ☐ Breastfed ☐ Formula ☐ Both ≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred Dietary Restrictions ☐ None ☐ Yes (list below) SCREENING TESTS 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) ☐ At risk (do BLL) ☐ Not at risk Child Care Only Hemoglobin or Hematocrit _____ g/dL _____ %									
Hearing < 4 years: gross hearing ____/____/____ ☐ NI ☐ Abnl ☐ Referred OAE ____/____/____ ☐ NI ☐ Abnl ☐ Referred ≥ 4 yrs: pure tone audiometry ____/____/____ ☐ NI ☐ Abnl ☐ Referred Vision <3 years: Vision appears: ____/____/____ ☐ NI ☐ 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																			
Child Receives EI/CPSE/CSE services ☐ Yes ☐ No CIR Number _____										Physician Confirmed History of Varicella Infection ☐ Report only positive immunity: IgG Titers Hepatitis B ____/____/____ Measles ____/____/____ Mumps ____/____/____ Rubella ____/____/____ Varicella ____/____/____ Polio 1 ____/____/____ Polio 2 ____/____/____ Polio 3 ____/____/____									
IMMUNIZATIONS – DATES DTP/DTaP/DT _____ Tdap _____ Td _____ MMR _____ Polio _____ Varicella _____ Hep B _____ Mening ACWY _____ Hib _____ Hep A _____ PCV _____ Rotavirus _____ Influenza _____ Mening B _____ HPV _____ Other _____																			
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					TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s) Comments:				
Facility Name										National Provider Identifier (NPI)					Date Reviewed: ____/____/____ I.D. NUMBER _____				
Address										City					State Zip				
Telephone										Fax					Email				
															FORM ID# _____				