

# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

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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

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____	<b>Does the child/adolescent have a past or present medical history of the following?</b> <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 <b>Explain all checked items above.</b>	<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) _____ <b>Addendum attached.</b>	<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
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<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____	<b>General Appearance:</b> <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 <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	<b>Describe abnormalities:</b> _____				

<b>DEVELOPMENTAL (age 0-6 yrs)</b> 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: _____	<b>Nutrition</b> < 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 <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____	<b>Hearing</b> 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	<b>Vision</b> Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test		
Describe Suspected Delay or Concern: _____	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	<b>Dental</b> Screened with Glasses? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 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	<b>Child Care Only</b> <b>Hemoglobin or Hematocrit</b> _____ g/dL _____ %		
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	CIR Number _____	Physician Confirmed History of Varicella Infection <input type="checkbox"/>	Report only positive immunity: IgG Titers Date Hepatitis B _____ Measles _____ Mumps _____ Rubella _____ Varicella _____ Polio 1 _____ Polio 2 _____ Polio 3 _____		

<b>IMMUNIZATIONS - DATES</b>	DTP/DTaP/DT _____ Tdap _____	MMR _____	Hepatitis B _____
Td _____	Polio _____	Varicella _____	Measles _____
Hep B _____	Hib _____	Mening ACWY _____	Mumps _____
PCV _____	Influenza _____	Hep A _____	Rubella _____
HPV _____		Rotavirus _____	Varicella _____
		Mening B _____	Polio 1 _____
		Other _____	Polio 2 _____
			Polio 3 _____

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <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 ____/____/____	<b>DOHMH ONLY PRACTITIONER I.D.</b> _____
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	<b>TYPE OF EXAM:</b> <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) <b>Comments:</b> _____
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ <b>I.D. NUMBER</b> _____
Address City State Zip	Telephone Fax Email	<b>REVIEWER:</b> _____
		<b>FORM ID#</b> _____