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** ☐ 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

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0–6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

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

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

If persistent, check all current medications: ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ 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)
☐ **Other** (specify) _____

Explain all checked items above or on addendum

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

Dietary Restrictions
☐ None ☐ Yes (list below)

PHYSICAL EXAMINATION

Height _____ cm (___ %ile)
Weight _____ kg (___ %ile)
BMI _____ kg/m² (___ %ile)
Head Circumference (age ≤2 yrs) _____ cm (___ %ile)
Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0–6 yrs) ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive (e.g., play skills) _____
☐ Communication/Language _____
☐ Social/Emotional _____
☐ Adaptive/Self-Help _____
☐ 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)	__/__/____	☐ At risk (do BLL) ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/____	☐ Normal ☐ 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	__/__/____	☐ Neg ☐ Pos
Interferon Test	__/__/____	☐ Neg ☐ Pos
Chest x-ray (if PPD or interferon positive)	__/__/____	☐ NI ☐ Abnl ☐ Not Indicated
Vision (required for new school entrants and children age 4–7 yrs)	__/__/____ ☐ with glasses	Acuity Right ___/___ Left ___/___ Strabismus ☐ No ☐ 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 ☐ Full physical activity ☐ Full diet

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/____

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

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** (list) **ICD-9 Code**

Health Care Provider Signature | Date __/__/____

Health Care Provider Name and Degree (print) | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

DOHMH ONLY PROVIDER I.D.

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

Comments

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

REVIEWER:

DH-205 (5/08)

Copies: White School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian