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 medication(s): ☐ Inhaled corticosteroid ☐ 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/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	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	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)*	___/___/___	☐ Nl ☐ 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 ID ______ TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s) Comments: Date Reviewed: I.D. NUMBER REVIEWER:

CH-205 (5/08)

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

SIGNIFIGANT HEALTH HISTORY

CURRENT CONDITIONS

Please list:

Medication Taken:

____

Appliance Worn (Glasses, Etc.) ____

Conditions Which Modify Activities (Seizures, Amnesia, Heart Conditions, Etc.) ________________

CONSENT FOR EMERGEMCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with understand that the family will be notified as soon as possible.

Relationship____________________________________

Signature____________________________________

Date____________________________________

Telephone____________________________________