

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY 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 (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name			
		Foster Parent			

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

Birth history (age 0-8 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
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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: NI Abnl <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Language <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine <input type="checkbox"/> Behavioral Describe abnormalities: _____
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS <table border="1"><thead><tr><th>Test</th><th>Date Done</th><th>Results</th></tr></thead><tbody><tr><td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td><td>____/____/____</td><td>____ µg/dL</td></tr><tr><td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td><td>____/____/____</td><td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td></tr><tr><td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td><td>____/____/____</td><td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td></tr><tr><td colspan="3" style="text-align: center;">Head Start Only</td></tr><tr><td>Hemoglobin or Hematocrit (age 9-12 mo)</td><td>____/____/____</td><td>____ g/dL ____ %</td></tr></tbody></table>	Test	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	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Head Start Only			Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed: ____/____/____ Induration _____ mm PPD/Mantoux read: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or interferon positive): ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl Vision (required for new school entrants and children age 4-7 yrs): ____/____/____ Acuity Right ____/____ Left ____/____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
Test	Date Done	Results																		
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IMMUNIZATIONS - DATES CIR Number of Child: _____ Hep B: ____/____/____ DTP/DTaP/DT: ____/____/____ PCV: ____/____/____	OTHER: MMR: ____/____/____ Td: ____/____/____ Meningococcal: ____/____/____ Other, specify: _____
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RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <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"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____
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Health Care Provider Signature	Date	DOHMH PROVIDER ONLY ID: _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NA (Direct) <input type="checkbox"/> NAE (Prep. year/s)
Facility Name	National Provider Identifier (NPI)	Comments: _____
Address	City State Zip	Date: ____/____/____
Telephone (____) _____	Fax (____) _____	REVIEWER: _____

SIGNIFIGANT HEALTH HISTORY
CURRENT CONDITIONS

Please list:

Medication Taken: _____

Appliance Worn (Glasses, Etc.) _____

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

CONSENT FOR EMERGENCY 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 _____