

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT IDENTIFICATION NUMBER

--	--	--	--	--	--	--	--	--	--

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			
		<input type="checkbox"/> Foster Parent					

Birth history (age 0-6 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/hearing 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) _____	
Explain all checked items above or on addendum					

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: <table border="0"> <tr> <td>NI Abnl</td><td>NI Abnl</td><td>NI Abnl</td><td>NI Abnl</td><td>NI Abnl</td> </tr> <tr> <td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</td><td><input type="checkbox"/> Skin</td><td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/> Gental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____				NI Abnl	NI Abnl	NI Abnl	NI Abnl	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"/> Gental	<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
NI Abnl	NI Abnl	NI Abnl	NI Abnl	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"/> Gental	<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																					

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) <small>(required at age 1 yr and 2 yrs and for those at risk)</small></td> <td>____/____/____</td> <td>____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small></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>Hemoglobin or Hematocrit <small>(age 9-12 mo)</small></td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>		Test	Date Done	Results	Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small>	____/____/____	____ µg/dL	Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small>	____/____/____	<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	Hemoglobin or Hematocrit <small>(age 9-12 mo)</small>	____/____/____	____ g/dL ____ %	Tuberculosis <small>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</small> PPD/Mantoux placed _____/____/____ Duration _____ 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 <small>(if PPD or Interferon positive)</small> _____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated Vision <small>(required for new school entrants and children age 4-7 yrs)</small> _____/____/____ Acuity Right _____/____ Left _____/____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes	
Test	Date Done	Results																		
Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small>	____/____/____	____ µg/dL																		
Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small>	____/____/____	<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																		
Hemoglobin or Hematocrit <small>(age 9-12 mo)</small>	____/____/____	____ g/dL ____ %																		

IMMUNIZATIONS - DATES CIR Number of Child _____		_____ MMR _____ _____ Td _____ _____ Meningococcal _____ _____ Other, specify: _____	
Hep B _____/____/____	DTP/DTaP/DT _____/____/____	PCV _____/____/____	_____

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 _____ _____ _____
--	---

Health Care Provider Signature		Date	DOHMH ONLY _____ _____ _____ _____
Health Care Provider Name and Degree (print)		Provider License No. and State	
Facility Name		National Provider Identifier (NPI)	
Address		City State Zip	
Telephone (____) _____	Fax (____) _____		_____