

**CHILD & ADOLESCENT HEALTH EXAMINATION FORM**  
 NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

**TO BE COMPLETED BY THE 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 \_\_\_\_\_ Call \_\_\_\_\_ Work \_\_\_\_\_

Health Insurance  Yes  No Parent/Guardian Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Email \_\_\_\_\_

**TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER**

Birth history (age 0-6 yrs)  
 Uncomplicated  Premature: \_\_\_\_\_ weeks gestation  
 Complicated by \_\_\_\_\_

Allergies  None  Epi pen prescribed  
 Drugs (list) \_\_\_\_\_  
 Foods (list) \_\_\_\_\_  
 Other (list) \_\_\_\_\_

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?  
 Asthma (check severity and attach MAF):  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  
 If persistent, check all current medication(s):  Quick Relief Medication  Inhaled Corticosteroid  Oral Steroid  Other Controller  None  
 Asthma Control Status:  Well-controlled  Poorly Controlled or Not Controlled

Anaphylaxis  Seizure disorder  
 Behavioral/mental health disorder  Speech, hearing, or visual impairment  
 Congenital or acquired heart disorder  Tuberculosis (latent infection or disease)  
 Developmental/learning problem  Hospitalization  
 Diabetes (attach MAF)  Surgery  
 Orthopedic injury/disability  Other (specify) \_\_\_\_\_  
 Explain all checked items above.  Addendum attached.

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

**PHYSICAL EXAM** Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

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) \_\_\_\_\_ / \_\_\_\_\_

General Appearance:  
 Physical Exam WNL  
 NI Abnl  Psychosocial Development  HEENT  Lymph nodes  Abdomen  Skin  
 Language  Dental  Lungs  Genitourinary  Neurological  
 Behavioral  Neck  Cardiovascular  Extremities  Back/spine

Describe abnormalities: \_\_\_\_\_

**DEVELOPMENTAL (age 0-6 yrs)**  
 Validated Screening Tool Used? \_\_\_\_\_ Date Screened \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Yes  No  
 Screening Results:  WNL  
 Delay or Concern Suspected/Confirmed (specify area(s) below):  
 Cognitive/Problem Solving  Adaptive/Self-Help  
 Communication/Language  Gross Motor/Fine Motor  
 Social-Emotional or Personal-Social  Other Area of Concern: \_\_\_\_\_

Describe Suspected Delay or Concern: \_\_\_\_\_

**SCREENING TESTS** 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)  At risk (do BLL)  Not at risk

**Hearing** Date Done \_\_\_\_\_ Results \_\_\_\_\_  
 < 4 years: gross hearing \_\_\_\_\_  NI  Abnl  Referred  
 OAE \_\_\_\_\_  NI  Abnl  Referred  
 ≥ 4 yrs: pure tone audiometry \_\_\_\_\_  NI  Abnl  Referred

**Vision** Date Done \_\_\_\_\_ Results \_\_\_\_\_  
 <3 years: Vision appears: \_\_\_\_\_  NI  Abnl  
 Acuity (required for new entrants and children age 3-7 years) \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_  
 Unable to test  
 Screened with Glasses?  Yes  No  
 Strabismus?  Yes  No

Child Receives EI/CPSE/CSE services  Yes  No

Hemoglobin or Hematocrit \_\_\_\_\_ g/dL \_\_\_\_\_ %

Visible Tooth Decay  Yes  No  
 Urgent need for dental referral (pain, swelling, infection)  Yes  No  
 Dental Visit within the past 12 months  Yes  No

Child Receives EI/CPSE/CSE services  Yes  No

Physician Confirmed History of Varicella Infection

Report only positive immunity:

IGG Titers	Date
Hepatitis B	____/____/____
Measles	____/____/____
Mumps	____/____/____
Rubella	____/____/____
Varicella	____/____/____
Polio 1	____/____/____
Polio 2	____/____/____
Polio 3	____/____/____

**ASSESSMENT**  Well Child (Z00.129)  Diagnoses/Problems (list) \_\_\_\_\_ ICD-10 Code \_\_\_\_\_

**RECOMMENDATIONS**  Full physical activity  
 Restrictions (specify) \_\_\_\_\_  
 Follow-up Needed  No  Yes, for \_\_\_\_\_ Appt. date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Referral(s):  None  Early Intervention  IEP  Dental  Vision  
 Other \_\_\_\_\_

Health Care Practitioner Signature \_\_\_\_\_ Date Form Completed \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Care Practitioner Name and Degree (print) \_\_\_\_\_ Practitioner License No. and State \_\_\_\_\_

Facility Name \_\_\_\_\_ National Provider Identifier (NPI) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

DOHMH ONLY PRACTITIONER I.D. \_\_\_\_\_

TYPE OF EXAM:  NAE Current  NAE Prior Year(s)  
 Comments: \_\_\_\_\_

Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_ I.D. NUMBER \_\_\_\_\_

REVIEWER: \_\_\_\_\_

FORM ID# \_\_\_\_\_