NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	**First Name** Jane Smith	**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**	**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 if 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
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ____________
☐ ***Addendum attached.***

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

PHYSICAL EXAM — **Date of Exam:** ___/___/___

Height	5'6"	cm	(____ %ile)
Weight	140	kg	(____ %ile)
BMI		kg/m²	(____ %ile)
Head Circumference *(age ≤2 yrs)*		cm	(____ %ile)
Blood Pressure *(age ≥3 yrs)*	____ / ____		

General Appearance:

☐ Physical Exam WNL

Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl	Nl 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? ☐ Yes ☐ No — Date Screened ___/___/___
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:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition
< **1 year** ☐ Breastfed ☐ Formula ☐ Both
≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred
Dietary Restrictions ☐ None ☐ Yes *(list below)*

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 *(at each well child exam, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— **Child Care Only** ——		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	***Date Done***	***Results***
< 4 years: gross hearing	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
OAE	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*

Vision	***Date Done***	***Results***
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *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

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

CIR Number ☐☐☐☐☐☐☐☐☐☐ — Physician Confirmed History of Varicella Infection ☐ — Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023		
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___	______	___/___/___

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 ____/____/____	**DOHMH ONLY** **PRACTITIONER I.D.** ☐☐☐☐☐☐
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	**TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) *Comments:*
Facility Name	National Provider Identifier (NPI)	
Address / City / State / Zip		Date Reviewed: ____/____/____ **I.D. NUMBER** ☐☐☐☐☐☐ REVIEWER:
Telephone / Fax	Email	**FORM ID#** ☐☐☐☐☐☐☐☐☐☐