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	Date of Birth (Month/Day/Year)
Robson	Mary Nick	Patrick	☐ Female ☐ Male	5 / 24 / 2017

Child's Address	Hispanic/Latino?	Race (Check ALL that apply)
go Bedford str	☐ Yes ☑ No	☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other werqwer

City/Borough	State	Zip Code	School/Center/Camp Name	District Number	Phone Numbers
New York	NY	10014	Lakeville Elementary School		Home Cell +1737225483 Work

Health insurance (including Medicaid)?		Last Name	First Name	Email
☐ Yes ☐ No	☑ Parent/Guardian ☐ Foster Parent	Robson	Ann	ann.robson@gmail.com

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	1800 cm	(___ ___ %ile)
Weight	500 kg	(___ ___ %ile)
BMI	1200 kg/m²	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	_____ cm	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	1200 / 800	

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 *(annually, 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)	07/07/19	Right 20 / 20 Left 20 / 20 ☐ 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	11/25/13	01/25/14	03/25/14	03/25/15	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	10/01/13	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	09/10/14	09/25/18
Polio	11/25/13	01/25/14	03/25/14	10/25/18	___/___/___	___/___/___	Varicella	03/25/15	09/25/18
Hep B	09/25/13	10/25/13	03/25/14	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	11/25/13	01/25/14	03/25/14	03/25/15	___/___/___	___/___/___	Hep A	09/25/15	03/25/16
PCV	11/25/13	01/25/14	03/25/14	03/25/15	___/___/___	___/___/___	Rotavirus	11/25/13	01/25/14
Influenza	10/25/14	10/25/15	10/25/16	10/25/17	10/25/18	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	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 07/07/2019

DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State
Jenna Brown	

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name	National Provider Identifier (NPI)
Pediatrician in Bellevue Hospital Center	BHC 321485

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Address	City	State	Zip
462 1st Avenue	New York	NY	10016

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+17003332110		j.brown@gmail.com

FORM ID#