

Department of Health and Mental Hygiene Department of Education

CHILD & ADOLESCENT	P
TEALTH EXAMINATION FORM	Print (

NYC ID (OSIS)

Health	OI Lauc	ation											
TO BE COMPLETED BY THE PA	ARENT C	R GUARDIAN											
Child's Last Name		First Name			Middle Name S			Sex	☐ Female	Date o	of Birth (Monti	ı/Day/Year)	
						- [-			☐ Male	<u> </u>	_/	<u>/</u>	
Child's Address					spanic/Latin Yes □ No		(Check ALL that apply tive Hawaiian/Pacifi				Asian 🗌 BI	ack 🗌 W	Vhite
City/Borough	State	Zip Code	School	/Center	/Camp Name	Э			District Number		Phone Numb Home		
Health insurance ☐ Yes ☐ Parent/Guardian	Last Name	First I	Name			Em	ail				Cell		
(including Medicaid)? No Foster Parent											Work		
TO BE COMPLETED BY THE HEAL Birth history (age 0-6 yrs)			hous o	noot or	u nuccont m	adiaal biat	ome of the follow	de a 2					
☐ Uncomplicated ☐ Premature: weeks ge		es the child/adolescent Asthma (check severity and a		P			Mild Persistent	············	Moderate Pers	sistent	☐ Severe	Persistent	
☐ Complicated by		If persistent, check all current me	edication(s)	_	uick Relief Med		Inhaled Corticosteroid		Oral Steroid	☐ Othe	er Controller	☐ None	
Ularaica ☐ None ☐ Epi pan prescribed ☐ Anaphylaxis									Medications (attach MAF if in-school medication needed)				
		Behavioral/mental health dis Congenital or acquired heart	disorder	□ T	Speech, hearir Tuberculosis (i	latent infection		□ No	one		Yes (list below)		
Drugs (list)		Developmental/learning prob Diabetes (attach MAF)	olem		lospitalization Surgery			-					
Foods (list)		Orthopedic injury/disability plain all checked items abo	ove.	\square 0	Other (specify) A ddendum at								
Other (list)						uonoui							
Attach MAF if in-school medications needed PHYSICAL EXAM Date of Exam:	/ / Ge	neral Appearance:											
Height cm (%ile)	norui Appouluilooi	☐ Phys	sical Exa	am WNL								
Weightkg (N/	AbnI ☐ Psychosocial Development	NI Abnl □ □ H			NI AbnI ☐ ☐ Lymp		VI <i>Abnl</i> □ □ Al:	ndomon		<i>NI AbnI</i> ☐ ☐ Skin		
BMI kg/m² (☐ Language				Lung:			enitourinary		□ □ Skiii	ogical	
Head Circumference (age ≤2 yrs) cm (☐ Behavioral	□ □ N	leck		☐ ☐ Cardi	ovascular		tremities		☐ ☐ Back/s	pine	
Blood Pressure (age ≥3 yrs) /	De	scribe abnormalities:											
DEVELOPMENTAL (age 0-6 yrs)	Nut	trition					Hearing		Da	te Done		Results	's
Validated Screening Tool Used? Date Screened < 1 year ☐ Breastfed ☐ F			ormula ☐ Both ☐ Needs guidance ☐ Counseled ☐ Referred				< 4 years: gross	s hearing/					
☐ Yes ☐ No/_	/	tary Restrictions ☐ None	-			□ Keierrea	OAE		_	/	_/ □N	_Abnl _	Referred
Screening Results: □ WNL □ Delay or Concern Suspected/Confirmed (specify area(s) below):						≥ 4 yrs: pure ton Vision	e audior		/_ ate Done	_/	Abnl Results	
☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help		CREENING TESTS	Date Done		Result		<3 years: Vision	appears		/			
☐ Communication/Language☐ Gross Motor/Fine Mo☐ Social-Emotional or☐ Other Area of Concer	17.1	ood Lead Level (BLL) quired at age 1 yr and 2	/_	/_		μg/dL	Acuity (required			/	Righ		/
Personal-Social		and for those at risk)	/_	/_		μg/dL	and children age	3-7 yea	irs) —			☐ Unable t	to test
(at e		Lead Risk Assessment (at each well child exam, age 6 mo-6 yrs)			At risk (do BLL) Screened with Glass Strabismus?				ses?				□ No □ No
			hild Care	Only —		atrion	Dental Visible Tooth Dec	cay				☐ Yes	□ No
		moglobin or	/	/		g/dL	Urgent need for o			0,	infection)	☐ Yes	
	res □ No He	matocrit				%	Dental Visit withi	n tne pa	ast 12 month	S			□ No
CIR Number		Phy	sician Co	ntirmed	History of Va	ricella Infecti	on 🔲				Report only	positive im	nmunity:
IMMUNIZATIONS – DATES		•		.							IgG Titers		
DTP/DTaP/DT//	_//	///	/	/	/ MMR		Tdap/	/	/	_/	Hepatitis B		/
Td///	_//		/		Varicella	//_	/	/	/	_/	Measles Mumps		/
Hep B/ /	//		/	Men	ing ACWY			/	/	_/	Rubella		/
Hib//	_//_	///	/		Нер А	//_		/	/_	_/	Varicella	/_	/
PCV//	//	//	/		Rotavirus	//		/	/_	_/	Polio 1	/_	/
Influenza//	_//	////	/		Mening B	//_	/	/	/	_/	Polio 2		/
HPV/////	//	s/Problems (list) ICD-	/ -10 Code	Other		/_	ull physical activity		/	_/	Polio 3	/_	/
ASSESSMENT Well Gillu (200.129)	Diagnoses	s/Fiobleilis (list)	TO GOUG	+	MMENDATION Strictions (spe		ull physical activity						
					v-up Needed		Yes, for				Appt. date:	_/	/
				Refer	ral(s):	None 🗆 I	Early Intervention		P 🗌 Dent	al 🗆	Vision		
Health Care Practitioner Signature				□ Oth	Date Form	Completed		D	OHMH PRA	CTITION	IER		
Hoolth Care Practitioner Name and Degree (c.)			Dr-	otition	r Liganes Ma	and Ctata	//		ONLY I.D.				V ()
Health Care Practitioner Name and Degree (print)			Pra	icuuonel	r License No.	anu state			(PE OF EXAN omments:	π: □ N/	AE Current	」NAE Prio	or year(s)
Facility Name			Nat	tional Pr	ovider Identif	ier (NPI)							
Address		City			Ctc+-	7:		Da	ate Reviewed	:	I.D. NUME	ER	
Address		City			State	Zip		RE	/ Eviewer:	_/			
Telephone	Fax			Ema	ail			F	DM ID#				