CHILD & ADOLESCENT IN NYC DEPARTMENT OF HEALTH & MENTAL I	HEALTI IYGIENE —	H EXAMINATIO DEPARTMENT OF EDUC	N FO	ORM Pl	ease	NYC ID (OSIS)											
TO BE COMPLETED BY THE I	PARENT	OR GUARDIAN	111 23	A MARK CONT. 18 1.	51503 51503 51555				11 17 14	통하는 100 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
Child's Last Name		First Name	1	Middle Nam	Branch Company	Sex											
Child's Address	L			Hispanic/Latin				////									
City/Borough	State	Zip Code	School	/Center/Camp Nami	Native Hawaiian/1 defile loid					Phone Numbers Home							
Health insurance ☐ Yes ☐ Parent/Guardia	n Last Name	e First I	Name		Em	ail				Cell							
(including Medicaid)? No Foster Parent						Work											
TO BE COMPLETED BY THE HEA								1 B 1 2 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	k k V P v P u B	2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	有限 (1) · 图 (1) · 图					
Birth history (age 0-6 yrs)	I F	Does the child/adolescent	have a	past or present m				Madazata Da			D						
☐ Uncomplicated ☐ Premature: weeks g	Jestanon	☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persister If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ Non															
Complicated by	<u> </u>	Asthma Control Status Well-controlled Poorly Controlled or Not Controlled Anaphylaxis Seizure disorder Medications (attach MAF if in-school medication neaded)															
Allergies None Epi pen prescribed		☐ Behavioral/mental health disorder ☐ Speech, hearing, or visual impairment ☐ None ☐ Yes (list below)															
☐ Drugs (list)		□ Developmental/learning prob	lem	Hospitalization	or disease)												
Foods (list)	—— I	Diabetes (attach MAF) Orthopedic injury/disability		☐ Surgery ☐ Other (specify)													
☐ Other (list)		Explain all checked items abo	ve.	☐ Addendum at	tached.												
Attach MAF if in-school medications needed																	
PHYSICAL EXAM Date of Exam:		General Appearance:	I □ Bhua	ical Exam WNL													
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· ·		Psychosocial Development			□ □ Lympi	h nodes	⊒ □ Ab			□ □ Skin							
BMIkg/m² (□ Language □ □ Behavioral			□ □ Lungs	1		☐ Genitourinary ☐ ☐ Neu☐ Extremities ☐ ☐ Bac									
Head Circumference (age ≤2 yrs) cm (%ii‰ ⊢	Describe abnormalities:		our .	[□ □ Carak	JVasculai L	_;	remues		☐☐☐ Back	spine						
Blood Pressure (age ≥3 yrs) /																	
DEVELOPMENTAL (age 0-6 yrs)	มีนี้จังค์ ซึ่ง N	Sutrition 1233 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			2 1 2 3 3 1 4 5 1	Hearing 222	4 4 4 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5	D	ate Done	有一型股份 (1) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Résults						
		< 1 year □ Breastfed □ Formo ≥ 1 year □ Well-balanced □ N			□ Referred	< 4 years: gross hearing/NiAbntReferred											
☐ Yes ☐ No/ Screening Results: ☐ WNL		Dietary Restrictions None Yes (list below)									ni 🗌 Referred						
☐ Delay or Concern Suspected/Confirmed (specify area	a(s) below):	$\geq 4 \text{ yrs; pure tone audiometry } $									/ □NI □Abni □Referred Results						
Cognitive/Problem Solving Adaptive/Self-Help	P8.5		ate Done	Result	<3 years: Vision appe												
☐ Communication/Language ☐ Gross Motor/Fine M☐ Social-Emotional or ☐ Other Area of Conce	1-	Blood Lead Level (BLL) (required at age 1 yr and 2	/_	_/	/ µg/dL Acuity (required for no						jht	_';					
Personal-Social		yrs and for those at risk)	/_	_/	_/ μg/dL and children age 3-7					_/ Lef		le to test					
Describe Suspected Delay or Concern:	I	_ead Risk Assessment 'annually, age 6 mo-6 yrs)	/_	At ris	At risk (do BLL) Screened with Glasse Strabismus?							□ No □ No					
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		СП demoglobin or	iid Care		g/dL	Visible Tooth Dec Urgent need for d	ay lental ref	orrol (nain	curollina	infantion)		Yes □ No					
Child Receives EI/CPSE/CSE services		lematocrit -	/_	_/	g, u.c	Dental Visit within				, инвошон)	_ \ □ \	Yes □ No Yes □ No;					
CIR Number	100 110	Phys	ician Con	ifirmed History of Vari	icella Infectio	n 🗆				Report only	positive	e immunity:					
IMMUNIZATIONS – DATES				•							$\dot{\tau}$						
DTP/DTaP/DT / / /	1 /		 f		 T	dap /	 1			IgG Titer Hepatitis		! 					
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Polio/////	_//		_/	Varicella _			/	/	/	Mump		/ /_					
Hep B//	//	///_	_/	Mening ACWY	//_	/	/	/	_/	Rubeli	a	.//_					
Hib//////	_//		_/	Hep A	//	/	/	/	_/	Varicell	a	.//					
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Influenza /_/_////	_''_	///	_/	Mening B	//	//	/	/	_/	Polio		.//					
HPV/////////		es/Problems (list) ICD-1	/_ O Code	Other RECOMMENDATION	/	/ II physical activity		/	_/	Polio	3	.//					
		ab) Todicito (tat)	O OULG	☐ Restrictions (speci	····	ii physical activity	·····										
				Follow-up Needed		es, for				Appt, date: _		,					
				Referral(s): 🔲 N			☐ IEP	☐ Dent		Vision							
				☐ Other													
Health Care Practitioner Signature				Date Form 0	Completed	, ,		HMH PRA		ER	TT						
Health Care Practitioner Name and Degree (print)			Pran	titioner License Mo. a	nd State	_//		ILY I.D.		E Currents	700	Pelos Venados					
			liac	androi Elucităt Nu. d						TYPE OF EXAM: NAE Current NAE Prior Year(s)							
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NUUI 003		City		State	Zip		2 5 2	i / · · · IEWER:		1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	14 8 10 10	124.4					
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CHILD & ADOLESCENT H	I EALT Ygiene –	H EXAMINATIO — DEPARTMENT OF EDU	N FO	ORM Plea Print Clea	ise	NYC ID (OSIS)	:									
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Child's Last Name	*****	First Name		Middle Name	<u> </u>	<u> 14 - 1 - 14 - 1</u> 5 - 15 - 16 - 16 - 16 - 16 - 16 - 16 - 1	Sex	☐ Female	Date	Date of Birth (Month/Day/Year)						
Child's Address				Hispanic/Latino?												
City/Borough	State	Zip Code	Schoo	I/Center/Camp Name	are navallant col	no idiano		Phone Numbers Home								
Health insurance	Last Nam	e First	Name		ail			Cell								
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Birth history (age 0-6 yrs)		Does the child/adolescent						<u>10(2644</u>	9 4 4 2	1分子林 年世 智 1	· · · · · · · · · · · · · · · · · · ·	4. 11 45	1,482			
☐ Uncomplicated ☐ Premature: weeks ge	- 11	☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ S											,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Complicated by	l	Asthma Control Status	suicationio	Well-controlled		inhaled Corticosteroid Poorly Controlled or i	_	Oral Steroid led	∐ Utr	ner Controller	∐ None	,				
Allergies 🗌 None 🔲 Epi pen prescribed]	□ Anaphylaxis □ Behavioral/mental health dis	order	☐ Seizure disorder ☐ Speech, hearing		imnairment				f in-school med		∍eded)				
☐ Drugs (list)		☐ Congenital or acquired hear ☐ Developmental/learning prot	disorder	☐ Tuberculosis (late			□ No	пе	Ш	Yes (list below	9					
☐ Foods (list)		☐ Diabetes <i>(attach MAF)</i> ☐ Orthopedic injury/disability)IGIII	☐ Surgery												
Other (list)	· JI	Explain all checked items ab	ove.	 Other (specify) Addendum atta 	ched.			_								
Attach MAF if in-school medications needed																
PHYSICAL EXAM Date of Exam:	//_	General Appearance:						-								
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BMIkg/m² (□ □ Language		ental 🗀	🛚 🗌 Lungs	3 i	☐ ☐ Ger	nitourinary		☐ ☐ Neuro	logical		İ			
Head Circumference (age ≤2 yrs)cm (wile) ⊢	Describe abnormalities:	<u> </u>	leck	☐ Cardi	ovascular	□ □ Ext	remities		□ □ Back/	spine					
Blood Pressure (age ≥3 yrs) / DEVELOPMENTAL (age 0-6 yrs)	- 138 KK A	Vairition of business of modern to be	1 4 1 1 5 V	DATE FALL OF NAME	77 1 1 1 2 T	A Bandina (at 5.1	9 5 7 5 9 9	· · · · · · · · · · · · · · · ·	to Divis	*** * * * * * * * * * * * * * * * * *	4313434		2124			
		< 1 year Breastfed Form			2 % pd 2 % ***	Hearing < 4 years: gros	4 2 2 2 4 4	1 4 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1	ie nané	日元张义而 萨莱米	Res i II ∐Abni		444.5			
□ Yes □ No/_		≥ 1 year □ Well-balanced □ N			Referred	OAE OAE	o nouring	_		:	vi ∟µoni Vi □Abni		- 1			
Screening Results: 🗀 WNL	i	Dietary Restrictions None	⊥ Yes (/	ist below)		≥ 4 yrs: pure tor	ne audiom	etry			ii □Abni	_				
 □ Delay or Concern Suspected/Confirmed (specify area) □ Cognitive/Problem Solving □ Adaptive/Self-Help 		SCREENING TESTS	Date Done	Results	24.20 M T T #	Vision			te Done		Rest	1.7				
Communication/Language Gross Motor/Fine Mo	tor i	Blood Lead Level (BLL)			⊥_µg/dL	<3 years: Vision Acuity (required			_/_	:	□ N/ [ht					
☐ Social-Emotional or ☐ Other Area of Concer Personal-Social		(required at age 1 yr and 2 Tyrs and for those at risk) _			μg/dL	and children age			_/_	_/ Left	•	_/	_			
Describe Suspected Delay or Concern:		Lead Risk Assessment	<u>:</u> -	 ☐ At risk	Screened with 6	Glasses?			☐ Unable to test ☐ Yes ☐ No							
		(annually, age 6 mo-6 yrs)	/_	/ Not at	rial	Strabismus?					☐ Yes					
		· 養養 施 斯 雅 等 / 2 · 3 · 4 · 4 · 4 · 4 · 4 · 4 · 4 · 4 · 4	ild Care	Only	IISK Landskird	Dental Visible Tooth De	cav			Table 1		es 🗀	∃ Nn			
	į.	Hemoglobin or	1	,	g/dL	Urgent need for (dental ref			infection)		es 🗆				
	<u>′es</u> □ No l	Hematocrit -		_′	%	Dental Visit with	in the pas	st 12 months	S 		☐ Ye	3S	□No			
CIR Number		Phy:	sician Co	nfirmed History of Varice	ella Infectio	on 🗆				Report only	positive	immuni	ity:			
IMMUNIZATIONS – DATES										lgG Titers	3 Date					
DTP/DTaP/DT///////	_//_		_/	//	٦	ſdap/	./	/	/	Hepatitis E		/_	_			
Polio / / / /	_//_		_/	MMR Varicella	_//_	' -	./	/	<u>/</u>	Measles		/_	-			
Hep B//		''		Mening ACWY	-'' 	 /	.' /		' I	Mumps Rubella		' ' '	_			
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PCV////	_//		_/	Rotavirus	_//_	/	/	/	/	Polio 1	/					
Influenza / / / / / /	_//	/////	_/	Mening B	_//_	/	./	/	/	Polio 2	2/	/_				
HPV/////	_/ <u>_/_</u>	//////	_/	Other	/_	/		/	<u>/</u>	Polio 3	<u>/</u>	/_				
ASSESSMENT Well Child (Z00.129)	∐ Diagnos	es/Problems (list) ICD-	10 Code	RECOMMENDATIONS ☐ Restrictions (specify,		n physical activity	······									
		·		Follow-up Needed		es for				Appt. date: _			$-\mid$			
				Referral(s):			☐ IEP	☐ Denta		Vision	· - ′	-'	-			
				☐ Other												
lealth Care Practitioner Signature				Date Form Co	mpleted			HMH PRAC VLY I'D.	CTITION	ER		ĪĪ	Ī			
lealth Care Practitioner Name and Degree (print)	•		Pra	ctitioner License No. and	TYPE OF EXAM: NAE Current NAE Prior Year(s											
acility Name			Nati	onal Provider Identifier	(NPI)		4 P 10	Reviewed:	10 4 5 10 4 5	TO NUMBER						
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CHILD & ADOL NYC DEPARTMENT OF HEA	ESCENT H	IEALTI YGIENE —	H EXAMINATIO - DEPARTMENT OF EDUC	N FO	ORM	Pleas Print Clearl		NYC ID (OSIS)	i i i i							
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Child's Last Name	人工 经基本条件 人名		First Name	<u></u>	N	liddle Name	<u> </u>		Sex	☐ Female						
Child's Address					anic/Latino? es 🗀 No		(Check ALL that app tive Hawaiian/Pac			an Asian Black White						
City/Borough	State	Zip Code School			amp Name	140	uvo navvaliann ao	ino istatu	District	Phone	Phone Numbers					
	☐ Parent/Guardian	Last Name	First I			Em	ail		<u> </u>	Cell						
(including Medicaid)? No	☐ Foster Parent	Lingual		12000	1310000	Crire di Si	10000	*********			Work _	(v v p v t		Art. Truat		
TO BE COMPLETED Birth history (age 0-6 yrs)	BY THE HEAL	TH CAR	E PRACTITIONER 153 Does the child/adolescent	have a	past or p	resent medic	cal hist	ory of the follo	wina?	ENTRE TH	74.344	1-9-1-1-1 1-3-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	(名包含)	ar ardit		
☐ Uncomplicated ☐ Premature: weeks gestation			Asthma (check severity and and if persistent, check all current me	ttach MAI	F): 🗌 Inter			Mild Persistent	Moderate Persis		evere Pers					
Complicated by			Asthma Control Status		☐ Well	-controlled		inhaled Corticosteroi Poorly Controlled or	Not Control	led	Other Control					
Allergies 🗌 None 🗀 Epi pen prescribed			□ Anaphylaxis □ Behavioral/mental health dis	order	☐ Spe	zure disorder ech, hearing, o	r visual i	impairment	Media □ No	c ations <i>(attach</i> one	MAF If In-school		ion neede	9d)		
☐ Drugs (list)		[☐ Congenital or acquired heart ☐ Developmental/learning prob	disordei Ilem	☐ Hos	erculosis (latent pitalization	t infection	or disease)								
☐ Foods (list)		—— I	☐ Diabetes (attach MAF) ☐ Orthopedic injury/disability			er (specify)			_							
Other (list)		^E	xplain all checked items abo	ove.	☐ Add	lendum attach	red.									
Attach MAF if in-school medic PHYSICAL EXAM	ations needed Date of Exam: /	/ / 6	General Appearance:													
Heightcm		%ile)	зенега муреаланса.	☐ Phy:	sical Exam	WNL	·····		·····							
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BM!kg/i	m² (☐ Language				i Lynnpi Lungs	I		nitourinary	- 1	kiii leurologia	cal			
Head Circumference (age ≤2 yrs)	cm (9/.ila\	☐ Behavioral Describe abnormallties:		Neck		☐ Cardio	ovascular	□ □ Ext	remities	□ □ B	ack/spin	е			
Blood Pressure (age ≥3 yrs) DEVELOPMENTAL (age 0-6 yrs)			othion as a constant of the	i di fi fi me d	F 74 (9 1 2 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		is in the	alian various de various		a	d= Bilde Main		NA B. W. W.	21 4 3 14-		
Validated Screening Tool Used?			1 year 🗌 Breastfed 🔲 Form			(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	110.311	Hearing < 4 years: gros			Done /	PERSONAL PROPERTY OF THE PROPE	2 th 20 kl]Referred		
☐ Yes ☐ No			1 year □ Well-balanced □ Nietary Restrictions □ None [Counseled 🗌 R	eferred	OAE OAE	io notaning		// //					
Screening Results: ☐ WNL ☐ Delay or Concern Suspected/Co	onfirmed lenegify aroule		iciary restrictions - Note:	165 (/	isi uciowj			≥ 4 yrs: pure to	ne audiom		<i></i>			Referred		
Cognitive/Problem Solving	Adaptive/Self-Help	š. 19.	SCREENING TESTS	ate Done	41 8 2 4 8 3 1 9 8 3 4 9 9	Results	i veril	Vision <3 years: Vision	aopears:		Done / /		Results Ni 🔲 /	1		
Social-Emotional or	☐ Gross Motor/Fine Mot ☐ Other Area of Concern	n: (/	llood Lead Level (BLL) required at age 1 yr and 2	/_	/	_	_μg/dL	Acuity (required and children age	for new o	entrants	//_	Right Left				
Personal-Social Describe Suspected Delay or Cor			rs and for those at risk)	′_	/	 ☐ At risk (6	μg/dL.	Screened with (-	-,			nable to			
		I	ead Risk Assessment annually, age 6 mo-6 yrs) —	/_	/	□ Not at ris	ŕ	Strabismus? Dental	uid5505?			□ Y	es [] No] No		
		8 : R.	**************************************	ild Care	Only.		(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)(日本)<td>Visible Tooth De</td><td>ecay</td><td></td><td></td><td></td><td>Yes</td><td>□ No</td>	Visible Tooth De	ecay				Yes	□ No		
Divisi Danata da EVODOE (ODE			lemoglobin or lematocrit —	/_	/	_	_ g/dL	Urgent need for Dental Visit with	dental ref		elling, infection	· :		□ No		
Child Receives EI/CPSE/CSE servi CIR N	umber Y	es 🗌 No 🗖		ician Co	nfirmed His	tory of Varicell	% a Infectio	<u></u>	iiii alo pa		Report	only posi				
MMUNIZATIONS – DATES			,.			and you random	a miosac	🗀								
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Influenza/		_//_		_/	Me	ning B			_/		_	olio 2				
HPV//	//	_//_	////////	_/	Other		/_	_/			Po	olio 3	_/_	_/		
ASSESSMENT Well Ch	hild (Z00.129)	Diagnose	es/Problems (list) ICD-1	O Code		ENDATIONS tions (specify) _	□ Fu	II physical activity	<i>!</i>							
		·			Follow-u	p Needed 🔲	No □1	es, for			Appt. dat	te:/	/	-		
					Referral(s): 🔲 None	□ Ea	arly Intervention	☐ IEP	☐ Dental	☐ Vision					
lealth Care Practitioner Signature	9				Other_	ate Form Comp	oleted	, ,		HMH PRACT	ŢĮOŅĘŖ Ę		i T			
lealth Care Practitioner Name an	d Degree (print)			Pra	actitioner License No. and State // ONLY ID A CONTROL OF TYPE OF EXAM: IN A CONTROL OF THE CONT							it 🔲 N	AE Prior	Year(s)		
acility Name				Nat	ional Provid	ler Identifier (N	PI)	<u> </u>	Comments, name of the property of the comments							
address			City		S	tate Zi	ip		3 5	e Reviewed:		IUMBER	property.			
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CHILD & ADOLESCENT NYC DEPARTMENT OF HEALTH & MENTAL	HE L HYG	ALTI	H EXAMINATION DEPARTMENT OF EI	OUC#	N FOF	RM P. Print C	lease learly		NYC ID (OSIS)										
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Child's Last Name			First Name	1 3 3 1 2 M	Middle Nar	& all your terms of the Australia	Female Date of Birth (Mo							- ρ γ ⊨4					
Child's Address		I		Hispanic/Latin			Check ALL that app		☐ American Indian ☐ Islander ☐ Other				//						
City/Borough	State	Zip Code School/			ol/Center/Camp Name			1 Native Hawaliaturacilic Isla			District Number			Phone Numbers Home					
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TO BE COMPLETED BY THE HE	ALT	H CARI	E PRACTITIONER	F E E E	# 17 7 7 3 3 3 11 4 3 4 3 4		· · · · · · · · · · · · · · · · · · ·	2000年 日本	A SHEAT A DAY	· 看到那些 · ·	T 1 1 2 3	***	union Gr	Work _	C. March	****	81 - 20 m	· 中国	
Birth history (age 0-6 yrs)		1.	loes the child/adolesce				1edical		ry of the follow					*****					
☐ Uncomplicated ☐ Premature: week	s gesta	ation L	Asthma (check severity and If persistent, check all curren					☐ Moderate Persistent ☐ Severe Persistent ☐ Oral Steroid ☐ Other Controller ☐ None											
Complicated by	_	-	Asthma Control Status] Anaphylaxis			 □ Well-controlled □ Seizure disord 	ler	☐ P	oorly Controlled or		*****************	(attaa	5 880E S	f in-schoo	l modi.				
Allergies 🗌 None 🗋 Epi pen prescribed			Behavioral/mental health Congenital or acquired he	dison	der	Speech, heariTuberculosis	ng, or v	isual ir	npairment	□ N		(artac		Yes (list		auon n	eeaea)		
☐ Drugs (list)			Developmental/learning p	roble	m	☐ Hospitalization ☐ Surgery	1 augun 1111 1	iecnon c	ii disease)										
Foods (list)		C	∃ Orthopedic injury/disabilit	ty		Other (specify				<u> </u>									
Other (list)		^E	xplain all checked items	apove	е,	Addendum a	ttached	1.		-									
Attach MAF if in-school medications needed PHYSICAL EXAM Date of Exam:	1	/ 6	onoral Annopropos															_	
Height cm (_		/	eneral Appearance:		☐ Physical	Exam WNL								·····	·· ····				
Weightkg (_			l Abni		VI Abni	_	NI Abr		- 1	Ni Abni				Ni Abni					
BMI kg/m ² (- ′ ∟] 🔲 Psychosocial Developme] 🔲 Language		□		1	Lymph Lungs		□		anv				nical			
Head Circumference (age ≤2 yrs) cm (_ (eli%)	☐ Behavioral		☐ Neck		1	-	vascular	□ □ Ex		-		□□В		•			
· ·		- 10.1C) D	escribe abnormalities:																
Blood Pressure (age ≥3 yrs) / / DEVELOPMENTAL (age 0-6 yrs)	645 A	A DESTRUCTION OF NO	utrition pagates exercises	413	- 11551	E TO THE BOOK OF THE	. I toget	Special Control	Hearing (1997)	i i baned	建有量金基	Dat	e Done	4. 10. M 10. M 11	1 12 14 21	Res	ults	27 4 7 E	
	Date So	reened <	1 year 🗆 Breastfed 🔲 Fo	rmula	a 🔲 Both			1212	< 4 years: gros			+ X \$ 2	1	1		□Abn	5 55	eferred	
□ Yes □ No	_/		1 year ☐ Well-balanced ☐ letary Restrictions ☐ No				☐ Refe	erred	OAE		•			J		□Abn			
Screening Results: WNL Delay or Concern Suspected/Confirmed (specify a	voolo) l		ional y mountains of the		100 mar t	ciowy			≥ 4 yrs: pure tor	ne audion	netry			J	□M	□Abn		ferred	
☐ Cognitive/Problem Solving ☐ Adaptive/Self-He			GRÉENING TESTS	Date	e Done	Resul	is ·	\$ 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Vision <3 years: Vision	annears			e Done /		, ·	Res.	to be a		
☐ Communication/Language ☐ Gross Motor/Fins			lood Lead Level (BLL)		/	/	hi	g/dL	Acuity (required				_'	-/ <u> </u>	Right		_/_		
Social-Emotlonal or Other Area of Co Personal-Social	oncern:		required at age 1 yr and 2 rs and for those at risk)	_	_/	/	Ц	g/dL	and children age	3-7 yea	rs)	_	_/	<i>J</i>	Left	Unabl	_ /_ e to te		
Describe Suspected Delay or Concern:		L	ead Risk Assessment			☐ At r	isk <i>(do l</i>		Screened with (Glasses?) Yes	<i>\</i> □ \		
			nnually, age 6 mo-6 yrs)	_	_/	./ □ Not	at risk		Strabismus? Dental	-						Yes		0	
			1	Child	l Care Onl	y + 2 + 3 + 5 + 5 + 5 + 5	1 N E 1		Visible Tooth De			. :				□ Y	es [□No	
			emoglobin or		1	/			Urgent need for					infection	1)			⊒ No	
Child Receives EI/CPSE/CSE services CIR Number	☐ Yes	□ No H	ematocrit	(f11				70	Dental Visit with	in the pa	St 12 m	ontns			!			⊐ No	
			, , , , , , , , , , , , , , , , , , ,	nysic	ian Contirn	ned History of Va	ricella ir	ntectici	וו					Report	anly p	ositive —	immu	nity:	
IMMUNIZATIONS – DATES DTP/DTaP/DT / / / /		·												······································	Titers	Date			
Td / / / /	—'	''		/	/	// MMR	,	, 10	lap/	/		<u></u>		Hepat			<u>''</u>	_	
Polio////				/ /	/	Varicella	/	- <i>'</i>	'	/		<u> </u>	<u>'</u>		asles Imps	—		-	
Hep B//////	/	/		<u>/_</u> .	/ N	Mening ACWY	/_	_/_	/	/			_	_	bella				
Hib////	/	/		/	/	Hep A	/_	_/_	/	/		/		Vari	cella		/		
PCV//////////	/	/	/	/	<i>I</i>	Rotavirus	/_	_/	/	/		/			lio 1		/	<u> </u>	
Influenza////	—′	'		<u>/</u>	/ Ot	Mening B	/	_/_	- ,/	/		''	<u>'</u>		olio 2		/	—	
ASSESSMENT Well Child (Z00.129)		Diagnose	s/Problems (list) IC	/ D-10		her COMMENDATION	JS	/ Full	physical activity			·		<u> </u>	olio 3		/	_	
· · · · · · · · · · · · · · · · · · ·					•••••	Restrictions (spec	· • • • • • • • • • • • • • • • • • • •												
					Fol	low-up Needed	□ No	□ Ye	es, for				/	Appt. dat	e:	_/	_/_		
		•				ferral(s): 🔲 N	lone	□ Ea	rly Intervention	□ IEP		Dental		l Vision					
Health Care Practitioner Signature		-			⊔	Other	Causulal						.1 1911	5 pt 3 mm		b			
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lealth Care Practitioner Name and Degree (print)				_	Practitio	ner License No.	and Stat	te	··	ΤΫ	2 2 7 F F	хам:	ide	\E Currer	ıt.	NAE P	rior Ye	ar(s)	
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