

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

Please Print Clearly NYC ID (0SIS)

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 _____ Cell _____ Work _____

Health insurance Yes No Parent/Guardian Last Name _____ First Name _____ Email _____ Cell _____ Work _____
 (including Medicaid)? No Foster Parent

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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

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

Allergies None Epi pen prescribed
 Drugs (list) _____
 Foods (list) _____
 Other (list) _____

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

Attach MAF if in-school medications needed

PHYSICAL EXAM Date of Exam: ____/____/____

Height _____ cm (____ %ile)
 Weight _____ kg (____ %ile)
 BMI _____ kg/m² (____ %ile)
 Head Circumference (age ≤2 yrs) _____ cm (____ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:
 Physical Exam WNL
 NI Abnl NI Abnl NI Abnl NI Abnl 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: _____

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

Hearing Date Done ____/____/____ Results _____
 < 4 years: gross hearing _____ NI Abnl Referred
 OAE _____ NI Abnl Referred
 ≥ 4 yrs: pure tone audiometry _____ NI Abnl Referred

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 _____ %

Developmental
 < 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

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

Describe Suspected Delay or Concern: _____

Child Receives EI/CPSE/CSE services Yes No

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

IMMUNIZATIONS - DATES		lgG Titers	Date
DTP/DTaP/DT	_____	Hepatitis B	_____
Td	_____	Measles	_____
Polio	_____	Mumps	_____
Hep B	_____	Rubella	_____
Hib	_____	Varicella	_____
PCV	_____	Polio 1	_____
Influenza	_____	Polio 2	_____
HPV	_____	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. NUMBER _____

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

Date Reviewed: ____/____/____ I.D. NUMBER _____

REVIEWER: _____

FORM ID# _____

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year)	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other			
City/Borough		State	Zip Code	School/Center/Camp Name		District Number	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name		Email		Cell _____ Work _____

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		Does the child/adolescent have a past or present medical history of the following? If persistent, check all current medication(s): Asthma Control Status: <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.					
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____					
Attach MAF if in-school medications needed							

PHYSICAL EXAM Date of Exam: ____/____/____ Height _____ cm (____%ile) Weight _____ kg (____%ile) BMI _____ kg/m ² (____%ile) Head Circumference (age ≤2 yrs) _____ cm (____%ile) Blood Pressure (age ≥3 yrs) _____ / _____		General Appearance: <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine Describe abnormalities: _____					
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DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____		Hearing Date Done ____/____/____ Results _____ < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
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) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Vision Date Done ____/____/____ Results _____ <3 years: Vision appears: _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right _____ Left _____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Hemoglobin or Hematocrit _____ g/dL _____ % Child Care Only		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
IMMUNIZATIONS - DATES DTP/DTaP/DT _____ Tdap _____ Td _____ MMR _____ Polio _____ Varicella _____ Hep B _____ Mening ACWY _____ Hib _____ Hep A _____ PCV _____ Rotavirus _____ Influenza _____ Mening B _____ HPV _____ Other _____				Hepatitis B _____ Measles _____ Mumps _____ Rubella _____ Varicella _____ Polio 1 _____ Polio 2 _____ Polio 3 _____	

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____			
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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: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)	
Facility Name		National Provider Identifier (NPI)		Comments: _____	
Address		City State Zip		Date Reviewed: _____ I.D. NUMBER _____	
Telephone		Fax		REVIEWER: _____	
Email		FORM ID# _____			

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (05IS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year)	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other			
City/Borough		State	Zip Code	School/Center/Camp Name			District Number	Phone Numbers Home
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name		Email		Cell
		Parent/Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/>						Work

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Asthma Control Status: <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.				Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)	
Attach MAF if in-school medications needed							

PHYSICAL EXAM Date of Exam: ____/____/____		General Appearance:							
Height _____ cm (____ %ile)		<input type="checkbox"/> Physical Exam WNL		<input type="checkbox"/> Ni Abnl		<input type="checkbox"/> Ni Abnl		<input type="checkbox"/> Ni Abnl	
Weight _____ kg (____ %ile)		<input type="checkbox"/> Psychosocial Development		<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
BMI _____ kg/m ² (____ %ile)		<input type="checkbox"/> Language		<input type="checkbox"/> Dental		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
Head Circumference (age ≤2 yrs) _____ cm (____ %ile)		<input type="checkbox"/> Behavioral		<input type="checkbox"/> Neck		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Extremities	
Blood Pressure (age ≥3 yrs) _____ / _____		Describe abnormalities:							

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened: ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ Describe Suspected Delay or Concern: _____		Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		Hearing Date Done: ____/____/____ Results: _____ < 4 years: gross hearing _____ <input type="checkbox"/> Ni <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> Ni <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry _____ <input type="checkbox"/> Ni <input type="checkbox"/> Abnl <input type="checkbox"/> Referred		Vision Date Done: ____/____/____ Results: _____ < 3 years: Vision appears: _____ <input type="checkbox"/> Ni <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right: ____/____ Left: ____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Child Care Only Hemoglobin or Hematocrit _____ g/dL _____ %		Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number _____		Physician Confirmed History of Varicella Infection <input type="checkbox"/>				Report only positive immunity:			
IMMUNIZATIONS - DATES									
DTP/DTaP/DT _____		Tdap _____				IgG Titers Date			
Td _____		MMR _____				Hepatitis B _____			
Polio _____		Varicella _____				Measles _____			
Hep B _____		Mening ACWY _____				Mumps _____			
Hib _____		Hep A _____				Rubella _____			
PCV _____		Rotavirus _____				Varicella _____			
Influenza _____		Mening B _____				Polio 1 _____			
HPV _____		Other _____				Polio 2 _____			
						Polio 3 _____			

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____					
		Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____					
		Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> 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: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)	
Facility Name _____		National Provider Identifier (NPI) _____		Comments: _____	
Address _____ City _____ State _____ Zip _____		Date Reviewed: ____/____/____		I.D. NUMBER _____	
Telephone _____ Fax _____ Email _____		REVIEWER: _____		FORM ID# _____	