



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		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 (including Medicaid)? ☐ No		☐ Parent/Guardian Last Name ☐ Foster Parent		First Name		Email		

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): If persistent, check all current medication(s): Asthma Control Status ☐ Anaphylaxis ☐ Behavioral/mental health disorder ☐ Congenital or acquired heart disorder ☐ Developmental/learning problem ☐ Diabetes (attach MAF) ☐ Orthopedic injury/disability Explain all checked items above.		☐ Intermittent ☐ Quick Relief Medication ☐ Well-controlled ☐ Seizure disorder ☐ Speech, hearing, or visual impairment ☐ Tuberculosis (latent infection or disease) ☐ Hospitalization ☐ Surgery ☐ Other (specify) _____ Addendum attached.		☐ Mild Persistent ☐ Inhaled Corticosteroid ☐ Poorly Controlled or Not Controlled ☐ Moderate Persistent ☐ Oral Steroid ☐ Other Controller ☐ None		Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below) _____ _____ _____ _____	
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Attach MAF if in-school medications needed

PHYSICAL EXAM Date of Exam: ____/____/____		General Appearance:																								
Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____		☐ Physical Exam WNL <table><tr><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td></tr><tr><td>☐ Psychosocial Development</td><td>☐ HEENT</td><td>☐ Lymph nodes</td><td>☐ Abdomen</td><td>☐ Skin</td></tr><tr><td>☐ Language</td><td>☐ Dental</td><td>☐ Lungs</td><td>☐ Genitourinary</td><td>☐ Neurological</td></tr><tr><td>☐ Behavioral</td><td>☐ Neck</td><td>☐ Cardiovascular</td><td>☐ Extremities</td><td>☐ Back/spine</td></tr></table>					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
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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	
Describe Suspected Delay or Concern: _____		SCREENING TESTS Date Done Results Blood Lead Level (BLL) ____/____/____ _____ µg/dL (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL		Vision Date Done Results <3 years: Vision appears: ____/____/____ ☐ NI ☐ Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____ Left ____/____/____ ☐ Unable to test	
		Lead Risk Assessment (at each well child exam, age 6 mo-6 yrs) ____/____/____ ☐ At risk (do BLL) ☐ Not at risk		Screened with Glasses? ☐ Yes ☐ No Strabismus? ☐ Yes ☐ No	
		Child Care Only		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	
Child Receives EI/CPSE/CSE services ☐ Yes ☐ No		Hemoglobin or Hematocrit ____/____/____ _____ g/dL ____/____/____ _____ %			

CIR Number		Provider Confirmed History of Varicella Disease ☐	Please attach lab reports
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IMMUNIZATIONS – DATES				Positive IgG Date	
DTP/DaP ____/____/____ Td ____/____/____				Hepatitis B ____/____/____	
Tdap ____/____/____ MMR ____/____/____				Measles ____/____/____	
Polio (IPV or OPV if before 4/1/2016) ____/____/____ Varicella ____/____/____				Mumps ____/____/____	
Hep B ____/____/____ Mening ACWY ____/____/____				Rubella ____/____/____	
Hib ____/____/____ Hep A ____/____/____				Varicella ____/____/____	
PCV ____/____/____ Rotavirus ____/____/____				Polio 1 ____/____/____	
Influenza ____/____/____ Mening B ____/____/____				Polio 2 ____/____/____	
HPV ____/____/____ Other ____/____/____				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 _____
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Health Care Practitioner Signature		Date Form Completed ____/____/____		DOHMH ONLY	PRACTITIONER I.D.
Health Care Practitioner Name (print)		Degree: ☐ MD ☐ DO ☐ NP ☐ PA		TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)	
Facility Name		Practitioner License No. and State		Comments:	
Address		National Provider Identifier (NPI)		Date Reviewed: ____/____/____ I.D. NUMBER	
Telephone		Fax		REVIEWER:	
City		State Zip		FORM ID#	
Email					