

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please
Print Clearly
Press Hard

TO BE COMPLETED BY 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"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White	
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				
		Foster Parent					

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ 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) _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
<i>Explain all checked items above or on addendum</i>		

PHYSICAL EXAMINATION 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: <table border="0"><tr><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td><td><i>NI Abnl</i></td></tr><tr><td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</td><td><input type="checkbox"/> Skin</td><td><input type="checkbox"/> Psychosocial Development</td></tr><tr><td><input type="checkbox"/> Dental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/> Language</td></tr><tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/> Behavioral</td></tr></table> Describe abnormalities: _____	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<i>NI Abnl</i>	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Language	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine	<input type="checkbox"/> Behavioral
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS	RESULTS	
	Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i> _____/_____/_____ _____ µg/dL	_____/_____/_____ _____ µg/dL	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed _____ Induration _____ mm PPD/Mantoux read _____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test _____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive) _____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl
	Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i> _____/_____/_____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE _____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Vision <i>(required for new school entrants and children age 4-7 yrs)</i> _____/_____/_____ <input type="checkbox"/> with glasses Acuity Right _____ / _____ Left _____ / _____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
Hemoglobin or Hematocrit (age 9-12 mo) _____/_____/_____ _____ g/dL _____ %	Head Start Only		

IMMUNIZATIONS - DATES CIR Number of Child _____	INFLUENZA _____
Hep B _____	MMR _____
Rotavirus _____	Varicella _____
DTP/DTaP/DT _____	Td _____
Hib _____	Tdap _____ Hep A _____
PCV _____	Meningococcal _____
Polio _____	HPV _____
	Other, specify: _____

RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <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"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature _____	Date ____/____/____
Health Care Provider Name and Degree (print) _____	Provider License No. and State _____
Facility Name _____	National Provider Identifier (NPI) _____
Address _____	City _____ State _____ Zip _____
Telephone (____) _____ - _____	Fax (____) _____ - _____