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 ☐ 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 ________

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

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ________________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ________________

☐ Foods *(list)* ________________

☐ Other *(list)* ________________

Attach MAF if in-school medications needed

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

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ____________

Explain all checked items above. ☐ ***Addendum attached.***

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

____

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

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl 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: ________

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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 ______ %

Hearing	***Date Done***	***Results***
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	***Date Done***	***Results***
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *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

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Polio	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	

Tdap	__/__/__	__/__/__	
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	__/__/__
Mening ACWY	__/__/__	__/__/__	__/__/__
Hep A	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__
Mening B	__/__/__	__/__/__	__/__/__
Other ________	__/__/__	________	__/__/__

IgG Titers	Date
Hepatitis B	__/__/__
Measles	__/__/__
Mumps	__/__/__
Rubella	__/__/__
Varicella	__/__/__
Polio 1	__/__/__
Polio 2	__/__/__
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 ____/____/____	**DOHMH ONLY** **PRACTITIONER I.D.** ☐☐☐☐☐☐
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	**TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) *Comments:*
Facility Name	National Provider Identifier (NPI)	
Address City	State Zip	Date Reviewed: ____/____/____ **I.D. NUMBER** ☐☐☐☐☐☐☐ REVIEWER:
Telephone Fax	Email	**FORM ID#** ☐☐☐☐☐☐☐☐☐☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

This page must be submitted to coach or athletic director before PSAL participation.

Last Name	First Name	OSIS#	Grade

School/Campus/ATSDBN

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**

❑ **NOT CLEARED** **Duration:** _____

❑ **NOT CLEARED PENDING FURTHER EVALUATION** _____

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____

_____

❑ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

❑ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

❑ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

❑ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

❑ **OTHER RESTRICTIONS** _____

_____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

❑ None ❑ Athletic Cup ❑ Sports/Safety Goggles ❑ Medical/Prosthetic Device ❑ Pacemaker ❑ Insulin Pump/Insulin Sensor
❑ Brace/Orthotic ❑ Hearing Aides ❑ Protective Ear Gear ❑ Other _____

❑ **PERTINENT MEDICAL HISTORY** _____

❑ **ALLERGIES** _____ ❑ None

MEDICATIONS

❑ Has prescribed pre-exercise medication _____

❑ Has prescribed PRN medication _____

❑ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

_____

❑ **OTHER RECOMMENDATIONS** _____

_____

_____

I have examined the above named student and completed the pre-participation physical examination, INCLUDING A REVIEW OF ANY MEDICAL HISTORY RELATED TO COVID-19. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI

Address	Medical Provider's Stamp

Phone	Fax	Email

Signature of medical provider	Date