NYC Health | 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 (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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

Allergies ☐ None ☐ Epinephrine 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? ☐ Yes ☐ No — Date Screened ___/___/___
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 *(at each well child exam, 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 ☐ Please attach lab reports

IMMUNIZATIONS – DATES

DTP/DTaP	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Tdap	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Polio (IPV or OPV if before 4/1/2016)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	

Td	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	__/__/__
Mening ACWY	__/__/__	__/__/__	__/__/__
Hep A	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__
Mening B	__/__/__	__/__/__	__/__/__
Other ______	__/__/__	__/__/__	__/__/__

Positive IgG	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 ___/___/___
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.** ☐☐☐☐☐☐☐
TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)
Comments:
Date Reviewed: ___/___/___ **I.D. NUMBER** ☐☐☐☐☐☐☐
REVIEWER:
FORM ID# ☐☐☐☐☐☐☐☐☐☐

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED, INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type:	
	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	Type: ☐ Intermittent ☐ Persistent ☐ Other:	
	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ **Seizures**	Type:	☐ Date of Last Seizure:
	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI_____ kg/m2
Percentile (Weight Status Category) ☐ <5th ☐ 5th - 49th ☐ 50th - 84th ☐ 85th- 94th ☐ 95th-98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ No ☐ Not Done | Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	**Positive**	**Negative**	**Date**	**Lead Level** Required for PreK & K	**Date**
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ **5** µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**
☐ **Abnormal Findings–List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list): ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening ☐ Pass ☐ Fail					☐

Notes:

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.	**Not Done**

Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes:

Scoliosis Screening Required for Boys grade 9 and Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐	☐

Notes:

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ **Family cardiac history reviewed** – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply, complete the information below.

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, or Volleyball
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.
- ☐ **Other Restrictions:**

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.