CHILD & ADOLESCENT HE NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE				FOR	Print	Please Clearly ss Hard	STU	DENT ID	NUMBEI OSI:									
TO BE COMPLETED BY PARENT OR GUARDIAN																		
Child's Last Name		Middle Name						Sex										
Child's Address														Vhite				
City/Borough State Zip Code Sci				chool/Center/Camp Name					District Phone Numbers									
Health insurance			First Name				Number					Home						
including Medicaid)?   No Foster Parent									Work									
TO BE COMPLETED BY HEALTH O	ARE PRO	VIDER	If "yes"	to an	y item,	pleas	se exp	olain (	attaci	adde	endum	, if ne	ede	d)				
Birth history (age 0-6 yrs)		t medical hi																
☐ Uncomplicated ☐ Premature: weeks gestation	and attach MAF/Astl rent medication(s):	thma Action Plan):																
☐ Complicated by ☐ Attention Deficit Hyperac				thick Disorder C Other district (district										d-d)				
Allergies ☐ None ☐ Epi pen prescribed				itis media						Medications (attach MAF if in-school medication needed)  ☐ None ☐ Yes (list below)								
☐ Drugs (list)	☐ Congenital or acqui ☐ Developmental/lear																	
☐ Foods (list)		s (attach MAF)	3 F		Other (specify)		outon or an											
	-								Dietary Restrictions  ☐ None ☐ Yes (list below)									
Other (list)	Other (list) Explai					ain all checked items above or on addendum												
PHYSICAL EXAMINATION	rance:																	
Heightcm (	NI Abni	NI Abni NI Abni NI Abni							I NI Abril									
Weightkg (	%ile)						-	Skin		☐ Psych		evelopm	ient					
BMIkg/m <sup>2</sup> (	Dental       Dental			☐ ☐ Lungs ☐ ☐ Genitourinary ☐ ☐ ☐ Cardiovascular ☐ ☐ Extremities ☐														
Head Circumference (age s2 yrs) cm (%ile) Describe abnormalities:																		
Blood Pressure (age ≥3 yrs) //																		
DEVELOPMENTAL (age 0-6 yrs)			Date Done Results						Da	ate Done		Results						
If delay suspected, specify below	Blood Lead Le	Lead Level (BLL)			ug/dl Tubero			losis Only required for students entering intermediate/middle/junior or high school										
☐ Cognitive (e.g., play skills)	(required at age 1 and for those at ri	red at age 1 yr and 2 yrs			µg/dL			who have not previously atte				ed any NYC public or private school						
		Lead Risk Assessment						PPD/Mantoux placed		/_	_/	Indura	tion	mm				
Communication/Language	(annually, age 6 m		//		☐ At risk (do BLL) ☐ Not at risk			antoux rea	ad		_/			□ Pos				
Social/Emotional	Hearing  Pure tone au	diometry			□ Normal		Interferon Test Chest x-ray			/_	_/	□ Ne		☐ Pos				
☐ Adaptive/Self-Help	OAE				Abnormal		(if PPD or Interferon po		positive)	//			Abnl Indicated					
	Unmaniahin ava			only —										-				
☐ Motor	Hemoglobin or Hematocrit (ago		//_		g/dL %		(required for new sch and children age 4-7				/	Acuity Right / Left / Strabismus \( \triangle \text{ No } \( \triangle \text{ Yes} \)						
IMMUNIZATIONS - DATES CIR Number		1 1		1							9							
of Child Hep B				Influenza/_						/_	_/	/		1				
Rotavirus/_ / / / / /				_/   MMR/_						/_	_'			/				
DTP/DTaP/DT/////////				Td							,		, and the same was	/				
//			/	Tdap/ /					Hep A//									
Hib////////				Meningococcal/_						/_								
PCV//					HPV//////////									1				
Polio					Other, specify:													
RECOMMENDATIONS ☐ Full physical activity ☐ Full diet					ASSESSMENT Well Child (V20.2) Diagnoses/Problems (list) ICD-9 Code													
Restrictions (specify)																		
Follow-up Needed		Appt. date:	_//															
Referral(s):   None   Early Intervention   Special	al Education [	□ Dental □	Vision	-							2							
Other																		
Health Care Provider Signature					Date / /				DOHMH PROVIDER ONLY I.D.									
Health Care Provider Name and Degree (print)				Provider License No. and State					TYPE OF EXAM: NAE Current NAE Prior Year(s)									
Facility Name Na				lational Provider Identifier (NPI)					- Comments									
Address City					State Zip					Date I.D. NUMBER Reviewed:								
Telephone		Fax						200	-	_/	/							