

# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please  
Print Clearly  
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STUDENT ID NUMBER: \_\_\_\_\_

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name <b>Moolani</b>		First Name <b>Camden</b>		Middle Name <b>Parlser</b>		Sex <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	Date of Birth (Month/Day/Year) <b>10/19/2014</b>
Child's Address <b>300 E 75th St Apt 32T</b>				Hispanic/Latino? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input checked="" type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other		
City/Borough <b>NY</b>		State <b>NY</b>	Zip Code <b>10021</b>	School/Center/Camp Name <b>Temple Emanu-El Nursery School</b>		District Number	Phone Numbers Home <b>202-276-7191</b> Cell <b>202-276-7191</b> Work <b>212-284-7899</b>
Health Insurance (including Medicaid)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Parent/Guardian Last Name <b>Moolani</b> <input type="checkbox"/> Foster Parent		First Name <b>Dana</b>			

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

<b>Birth history</b> <i>(age 0-6 yrs)</i> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma <i>(check severity and attach MAF/Asthma Action Plan):</i> <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	
<b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed  <input type="checkbox"/> Drugs <i>(list)</i> _____  <input type="checkbox"/> Foods <i>(list)</i> _____  <input type="checkbox"/> Other <i>(list)</i> _____		<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 <i>(latent infection or disease)</i> <input type="checkbox"/> Diabetes <i>(attach MAF)</i> <input type="checkbox"/> Other <i>(specify)</i> _____	
		<b>Medications</b> <i>(attach MAF if in-school medication needed)</i> <input type="checkbox"/> None <input type="checkbox"/> Yes <i>(list below)</i> _____ _____	
		<b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes <i>(list below)</i> _____ _____	

## PHYSICAL EXAMINATION

Height \_\_\_\_\_ cm ( \_\_\_\_\_ %ile)  
Weight \_\_\_\_\_ kg ( \_\_\_\_\_ %ile)  
BMI \_\_\_\_\_ kg/m<sup>2</sup> ( \_\_\_\_\_ %ile)  
Head Circumference (*age ≤ 2 yrs*) \_\_\_\_\_ cm ( \_\_\_\_\_ %ile)  
Blood Pressure (*age ≥ 3 yrs*) \_\_\_\_\_ / \_\_\_\_\_

**General Appearance:**

NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI Abnl
<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

**Describe abnormalities:**

**DEVELOPMENTAL** (age 0-6 yrs) ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive (e.g., play skills) \_\_\_\_\_

☐ Communication/Language \_\_\_\_\_

☐ Social/Emotional \_\_\_\_\_

☐ Adaptive/Self-Help \_\_\_\_\_

☐ Motor \_\_\_\_\_

## SCREENING TESTS

<b>Blood Lead Level (BLL)</b> <i>(required at age 1 yr and 2 yrs  for those at risk)</i>	____/____/____	____ μg/dL
<b>Lead Risk Assessment</b> <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<input type="checkbox"/> At risk <i>(do BLL)</i> <input type="checkbox"/> Not at risk
<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Head Start Only</b>		
<b>Hemoglobin or  Hematocrit (age 9-12 mo)</b>	____/____/____	____ g/dL ____ %

	Date Done	Results
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<b>Tuberculosis</b> <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 <input type="checkbox"/> Abnl <input type="checkbox"/> Indicated
Vision (required for new school entrants and children age 4-7 yrs)	___ / ___ / ___ <input type="checkbox"/> with glasses	Acuity Right ___ / ___ Left ___ / ___ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes

### IMMUNIZATIONS – DATES

[illegible]

## RECOMMENDATIONS

☐ Restrictions (specify) \_\_\_\_\_

**Follow-up Needed**    ☐ No    ☐ Yes, for \_\_\_\_\_    Appt. date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Referral(s):**    ☐ None    ☐ Early Intervention    ☐ Special Education    ☐ Dental    ☐ Vision

☐ Other \_\_\_\_\_

## ASSESSMENT

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Care Provider Signature		Date	DOHMH ONLY	PROVIDER ID
Health Care Provider Name and Degree (print)		Provider License No. and State	TYPE OF EXAM	<input type="checkbox"/> NAE Current <input type="checkbox"/> NAE End Year(s)
Facility Name		National Provider Identifier (NPI)	Comments	
City		State	Date	TOTAL NUMBER
Zip			Reviewed	
Fax			REVIEWER	