

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, Date of Birth, Child's Address, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email, Cell, Work

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF in in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities

DEVELOPMENTAL, Validated Screening Tool Used, Screening Results, Describe Suspected Delay or Concern, Nutrition, Dietary Restrictions, Hearing, Vision, Acuity

SCREENING TESTS, Blood Lead Level (BLL), Lead Risk Assessment, Hemoglobin or Hematocrit, Dental, Child Care Only

Child Receives EI/CPSE/CSE services, CIR Number, Physician Confirmed History of Varicella Infection, Report only positive immunity

IMMUNIZATIONS - DATES, DTP/DtaP/DT, Tdap, Polio, Hep B, Hib, PCV, Influenza, HPV, Mening B, Other, IgG Titers, Date

ASSESSMENT, Well Child (Z00.129), Diagnoses/Problems (list), ICD-10 Code, RECOMMENDATIONS, Full physical activity, Restrictions (specify), Follow-up Needed, Referral(s)

Health Care Practitioner Signature, Date Form Completed, Health Care Practitioner Name and Degree, 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, Comments, Date Reviewed, I.D. NUMBER, REVIEWER, FORM ID#