

Health Information

Please check any box that applies to your child

	YES	NO		YES	NO
Allergies to food (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions Seizers	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medicine (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	Corrective Device (glasses, hearing, aid etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Individualized Education Plan	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral/Emotional issues	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)					

Children who have special health care needs are those who have chronic physical, developmental, behavioral, or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that are required by children generally. If your child does have, special health care needs please discuss these with your childcare provider.

Please explain: _____

Does your child have special health care needs that require treatment and/or medication? YES NO

Please explain: _____

Does your child take medication for any condition or illness YES NO

Please explain: _____

Are there any activities your child cannot participate in? YES NO If yes, please specify

Please explain: _____

CERTIFICATION STATEMENT

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of this program. I consent to the enrollment and participation of the child listed above in this program. I understand that if my child has a seizure or any other anticipated medical reaction while attending this program, I will not hold UAU responsible.

Applicant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Teacher in Charge _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____ Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name		Foster Parent <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <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 <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 (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
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Explain all checked items above or on addendum

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="0"> <tr> <td><input type="checkbox"/> NI Abnl</td> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> Lymph nodes</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> <td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/> Back/spine</td> <td><input type="checkbox"/> Behavioral</td> <td></td> </tr> </table> Describe abnormalities: _____	<input type="checkbox"/> 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"/> HEENT	<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	
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS <table border="1"> <thead> <tr> <th>Test</th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i></td> <td>____/____/____</td> <td>____ μg/dL</td> </tr> <tr> <td>Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i></td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>	Test	Date Done	Results	Blood Lead Level (BLL) <i>(required at age 1 yr and 2 yrs and for those at risk)</i>	____/____/____	____ μg/dL	Lead Risk Assessment <i>(annually, age 6 mo-6 yrs)</i>	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Tuberculosis <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 Indicated <input type="checkbox"/> Abnl
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IMMUNIZATIONS - DATES CIR Number of Child: _____	Influenza: ____/____/____ MMR: ____/____/____ Varicella: ____/____/____ Td: ____/____/____ Tdap: ____/____/____ Hep A: ____/____/____ Meningococcal: ____/____/____ HPV: ____/____/____ Other, specify: _____
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RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____
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Health Care Provider Signature	Date	DOHMH ONLY PROVIDER I.D.
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	State
Telephone (____) _____	Fax (____) _____	Date Reviewed: ____/____/____ REVIEWER: _____