

# 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 <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 <input type="checkbox"/> Yes <input type="checkbox"/> No (including Medicaid)? <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email			
		Foster Parent <input type="checkbox"/>						

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <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 (check severity and attach MAF): <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"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
<b>Allergies</b> <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) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability <b>Explain all checked items above.</b>			<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <b>Addendum attached.</b>		
<b>Attach MAF if in-school medications needed</b>		<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____		<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine					
Height _____ cm (____ %ile)	Weight _____ kg (____ %ile)	BMI _____ kg/m <sup>2</sup> (____ %ile)	Head Circumference (age ≤2 yrs) _____ cm (____ %ile)	<b>Describe abnormalities:</b>			
Blood Pressure (age ≥3 yrs) _____ / _____							

<b>DEVELOPMENTAL (age 0-6 yrs)</b> Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		<b>Nutrition</b> <input type="checkbox"/> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		<b>Hearing</b> Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern: _____		<b>SCREENING TESTS</b> Date Done ____/____/____ Results <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL <b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		<b>Vision</b> Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Hemoglobin or Hematocrit</b> _____ g/dL _____ %		<b>Dental</b> Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:			
<b>IMMUNIZATIONS - DATES</b>						IgG Titers	Date
DTP/DTaP/DT	_____	_____	_____	_____	_____	Hepatitis B	_____
Td	_____	_____	_____	_____	_____	Measles	_____
Polio	_____	_____	_____	_____	_____	Mumps	_____
Hep B	_____	_____	_____	_____	_____	Rubella	_____
Hib	_____	_____	_____	_____	_____	Varicella	_____
PCV	_____	_____	_____	_____	_____	Polio 1	_____
Influenza	_____	_____	_____	_____	_____	Polio 2	_____
HPV	_____	_____	_____	_____	_____	Polio 3	_____

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	
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Health Care Practitioner Signature		Date Form Completed ____/____/____		<b>DOHMH ONLY PRACTITIONER I.D.</b> _____	
Health Care Practitioner Name and Degree (print)		Practitioner License No. and State		<b>TYPE OF EXAM:</b> <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____	
Facility Name		National Provider Identifier (NPI)		Date Reviewed: ____/____/____ <b>I.D. NUMBER</b> _____	
Address		City		State Zip	
Telephone		Fax		Email	
				<b>FORM ID#</b> _____	



## Head Start Oral Health Form—Children

### Patient Information

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Parent's/guardian's name \_\_\_\_\_ Phone number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
This practice is the child's dental home: Yes No

### Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)  
Does the child have any teeth that have previously been treated for decay, including fillings, crowns,  
or extractions? Yes No  
Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

### Oral Health Care Services Delivered During Visit

<b>Diagnostic/Preventive Services</b>			<b>Counseling/Anticipatory Guidance</b>			<b>Restorative/Emergency Care</b>		
Examination:	Yes	No	Yes	No	Fillings:	Yes	No	
X-rays:	Yes	No			Crowns:	Yes	No	
Risk assessment:	Yes	No	<b>Referral to Specialty Care</b>		Extractions:	Yes	No	
Cleaning:	Yes	No	Yes	No	Emergency care:	Yes	No	
Fluoride varnish:	Yes	No	_____		Other:	_____		
Dental sealants:	Yes	No	<i>(Please specify specialist)</i>		<i>(Please specify)</i>			

### Future Oral Health Care Services

All treatment completed: Yes No Next recall date: \_\_\_\_\_ / \_\_\_\_\_ (month/year)  
More appointments needed for treatment? Yes No  
If yes: Approximate number of appointments needed: \_\_\_\_\_ Next appointment: Date: \_\_\_\_\_ Time: \_\_\_\_\_

### Additional Information for Parents, Head Start Staff, and Medical Providers

### Oral Health Provider's Contact Information and Signature

Provider name *(please print)* \_\_\_\_\_ Phone number \_\_\_\_\_ Fax number \_\_\_\_\_  
Practice name \_\_\_\_\_ Address \_\_\_\_\_  
Provider signature \_\_\_\_\_ Date of service \_\_\_\_\_

# Goddard Riverside

INVESTING IN PEOPLE, STRENGTHENING COMMUNITY

## Early Childhood Department Vision and Hearing Subjective Screening Form

**DIRECTIONS:** Our governing bodies require that every child in our school has a yearly subjective hearing and vision test done.

A subjective vision test can be performed by holding your finger up, moving it side to side and asking the child to follow it with their eyes. The hearing test can be performed by asking the child a question or to perform a basic task and if they respond appropriately then they have passed.

Once completed, please fill in the information below by selecting if the child passed or failed.

Child's Name: \_\_\_\_\_

Date of Test: \_\_\_\_\_

Has Passed the subjective Hearing Screening.

Has Failed the subjective Hearing Screening.

Has Passed the subjective Vision Screening.

Has Failed the subjective Vision Screening.

Physician's Signature: \_\_\_\_\_

Name and Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Or Stamp Below**