CHILD & ADOLESCENT H	IEALTI YGIENE —	HE DE	XAMINATION PARTMENT OF EDU	ON F	OF N	RM Print	Please Clearly		NYC ID (OSIS)										
TO BE COMPLETED BY THE PARENT			GUARDIAN																
Child's Last Name			First Name			Middle Name				Sex	□ Fe		Date (of Birt	h (Mont	h/Day/Y	ear)		
Child's Address					Hispanic/Latino? Race (Check ALL that apply) Yes No Native Hawaiian/Pacific Is					American Indian Asian Black White									
City/Borough State		Zip Code Sch			nool/Center/Camp Name			Distric Numbe			_	Phone Numbers Home							
Health insurance			me First Name			Ema			nil						Gell				
TO BE COMPLETED BY THE HEAL														94					
Birth history (age 0-6 yrs)					a past or present medical history of the followards: Intermittent					ing? Moderate Persistent Severe Persis						and the second			
Uncomplicated Premature: weeks gestation			sistent, check all current r								☐ Oral Steroid ☐ Other Controller ☐ None								
Complicated by			ma Control Status		☐ Well-controlled ☐ Poorly Controlled or Not C														
Allergies None Epi pen prescribed			Anaphylaxis Behavioral/mental health disorder				 Speech, hearing, or visual impairment 					Medications (attach MAF if in-school medication needed) □ None □ Yes (list below)							
Drugs (list)			Congenital or acquired heart disorder Developmental/learning problem Diabetes (attach MAF)				Tuberculosis (latent infection or disease) Hospitalization												
Foods (list)			etes <i>(attach MAF)</i> opedic injury/disability		Surgery Other (spe														
Other (list)			Explain all checked items above.				Other (specify) Addendum attached.												
Attach MAF in in-school medications needed									(6)										
PHYSICAL EXAM Date of Exam:		Genera	Appearance:	.0000000000	1160000	ctres occasions vertica	ten 500 ten 100 t	roupeaner o			d0000000	**********	1000000000	************	os/honco	50084500000			
	%ile)					Exam WNL	100		191					e:					
Weightkg (NI Abni	sychosocial Developmer	NI Ab nt □ □		uт	NI A	4 <i>bni</i> □ Lympi		<i>NI Abnl</i> □ □ At	ndome	n		NI Ab	n/ Skin				
· —			anguage		Dent			_ Lungs							Neuro	logical			
Head Circumference (age ≤ 2 yrs) cm (— %ile)	□□В	ehavioral) Neck	<				□ □ Ex				op	Back/s	spine			
		Describ	e abnormalities:																
Blood Pressure (age ≥3 yrs) // DEVELOPMENTAL (age 0-6 yrs)		Nutritio	6						Kearing			Ла	te Done			D	sults		
and the Property of the Control of t		1000010000	!! r □ Breastfed □ For	mula 🗆	Both				< 4 years: gross	e haarin	0	Da	le Duile	1	1 DA		ni Referred		
☐ Yes ☐ No	,	≥1 year	r 🗌 Well-balanced 🗌	Needs g	guidan	ice 🗌 Counse	eled 🗌 Re	eferred	OAE	o ilicarili	y			1	13		ni Referred		
Screening Results: WNL		Dietary	Restrictions None	e 🗌 Yes	(list L	below)			≥ 4 yrs; pure ton	e audion	netry	_		/			ni Referred		
Delay or Concern Suspected/Confirmed (specify area(s) below):							Vision				Date Done Results								
Cognitive/Problem Solving Adaptive/Self-Help			SCREENING TESTS Date Done				Results <3 years: Vision				5:		_/_				☐ Abnl		
☐ Communication/Language ☐ Gross Motor/Fine Mi☐ Social-Emotional or ☐ Other Area of Conce			.ead Level (BLL) ed at age 1 yr and 2	/	_	_/		µg/dL	Acuity (required and children age			nts	1	1		ht			
Personal-Social			for those at risk)	/		_/		µg/dL	ano chiloren age	: 3-7 yea	irs)						ble to test		
Describe Suspected Delay or Concern:		Lead Ri	isk Assessment	,	,	, 🗆	At risk (d	to BLL)	Screened with G	Glasses?	•					☐ Yes			
			(annually, age 6 mo-6 yrs)				/ Not at risk			Strabismus? Yes No							□ No		
				Child Ca	re On				Visible Tooth Dec	cay							Yes 🗆 No		
			Hemoglobin or								tal referral (pain, swelling, infection) 🔲 Yes 🔲 No								
Child Receives EI/CPSE/CSE services	Yes 🗆 No	Hemato	ocrit	- T.		V. 17		_ %	Dental Visit with	in the pa	ast 12	month	S		1		Yes No		
CIR Number			Ph	nysician (Confir	med History o	of Varicella	a Infectio	on 🗆					Repo	ort only	positiv	e immunity:		
IMMUNIZATIONS – DATES														lg	G Titer:	s Dat	е		
DTP/DTaP/DT///////	//		_///	/_		//	_	1	Гdар/	/	_	_/		Hep	oatitis E	3	//_		
Td//	//	_	_///	/	_	MMR	/	//_	/	/	-	_/_	./:	1	Measle	s	11		
Polio///	//		_///	/_	_	Varicella			/	/		_/			Mump	s			
Hep B//	_//_		_///	/_	_	Mening ACWY			/	/	_	_/			Rubella	a	11		
Hib///	_//_		_''	/	_	Hep A			— i — /	/	_	_/		'	/aricella	a	//		
PCV///	_//_	-	_''	/_	_	Rotavirus				/		_/	-/		Polio				
Influenza////	'	-	-''	/_	-	Mening B	3			_	-	- /	/		Polio 2	-	_//_		
HPV	/_ //		<u> </u>	100		ther	TIONS					_/			Polio 3	3	<i>II</i>		
ASSESSMENT Well Child (Z00.129)	☐ Diagnos	ses/Pro	DIEMS (list) ICL	0-10 Cod	****	ECOMMENDA		FL	ill physical activity			*********		*******	++++++				
					-	Restrictions		No 🗆	Voc. for					Annt	data		,		
		Follow-up Needed No Yes, for Appt. date:// Referral(s): None Early Intervention IEP Dental Vision											'						
					- 1	Other													
Health Care Practitioner Signature						Date Form Completed					DOHMH PRACTITIONER								
Health Care Practitioner Name and Degree (print)						Practitioner License No. and State					TYPE OF EXAM: NAE Current NAE Prior Year(s) Comments:								
Facility Name						National Provider Identifier (NPI)					Date Reviewed: I.D. NUMBER								
Address City						State Zip					REVIEWER:								
Felephone	Fax					Email				FC	ORM IC	D# [T	T	TT	-	ПП		