TO BE COMPLETED BY THE PARENT OR GLARDIAN Order Lates Name First Name Niddle Name Set First Name Niddle Name Child's Address Integenic/Latin? Race One AL datappy Anterian folian Name ////////////////////////////////////	CHILD & ADOLESCENT H NYC DEPARTMENT OF HEALTH & MENTAL HY	EALTI GIENE -	H EXAMINATIO	DN F	ORM	Plea Print Clea		NYC ID (OSIS)									
Child's Address Itepanic/Latino? Rate Check AL dar apply Anticidan Male ////////////////////////////////////	TO BE COMPLETED BY THE P.	ARENT	OR GUARDIAN														
City Usrough State Zip Code School/Centr/Camp Name District From / From	Child's Last Name	First Name			Middle Name			Sex					Year)				
City/Boreugh State Zip Code School/Center/Camp Name Definition Phone Numbers Health insurance	Child's Address		<u>I</u>														
globalding Medical(r)? No Perster Parent Work TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER Work Work Bith history gar 64 pint Obes the child/addelescent have a past or present medical history of the following? Module Perster Second Paratech Complicated Premature: weeks gestation Module Second Paratech Module Second Paratech Duscomplicated Premature: weeks gestation Second Red Medication Module Second Paratech Duscomplicated Premature: weeks gestation Second Red Medication Module Second Paratech Duscomplicated Premature: Weeks cancelland Paratech Module Second Paratech Module Second Paratech Probase (are paratech Physical Estation Paratech Second Red Paratech Medications and Paratech Medications and Paratech Probase (are paratech Physical Estation Paratech Addevent Second Red Paratech Medications and Paratech Physical Estation Date of Exam //// General Appearance: Physical Estation Medications and Paratech Physical Estation Date of Exam ////////////////////////////////////	City/Borough	State	Zip Code School/Ce														
TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER www.minutestical history of the following? Birth history of 0 # 0% Does the child/adolescent have a past or present medical history of the following? Uncomplicated by part 0 # 0% Does the child/adolescent have a past or present medical history of the following? Complicated by Does the child/adolescent have a past or present medical history of the following? Complicated by Does the child/adolescent have a past or present medical history of the following? Attema Control Status Attema Control Attema Control Status Attema Control Does the child/adolescent Drops file Decomplication Status Medication Attema Control Drops file Decomplication Decomplication Decomplication Decomplication Drops file Decomplication Status Decomplication Decomplication Prescal Explant all checked filems above. Decomplication Decomplication Drops file Com Status Prescal Ecom Decomplication Prescal Status Prescal Decomplication Decomplication Delto Ecom	Health insurance Yes Parent/Guardian	Last Nam	ne First		Email							Cell					
Bith Integration (app 4 - 6 - 70) Desc the child/addressent have a past or present metical history of the following? Uncomplicated Premature: weeks gestation	(including Medicaid)? No Foster Parent												Work				
Uncomplicated Premature: weeks gestation Indergies None Drugs (ids) Stationa (check severity and attach MdP) Indergies None Drugs (ids) Spaceh, hearing, or valued impairment Drugs (ids) Spaceh, hearing, or valued impairment Drugs (ids) Developmental/decimits problem Drugs (ids) Developmental/decimits problem Drugs (ids) Deter (ids) Dther (ids) Central Appearance: Prysical Exam // Addendum attached. Height Con Con Spaceh, hearing, or valued exit (dorder beam while) Dither (ids) Spaceh, hearing, or valued exit (dorder beam while) Physical Exam Developmental/decimits problem Dither (ids) Spaceh, hearing, or valued exit (dorder beam while) Weight kg Height Con Con Spaceh, hearing Weight kg Height Con Con Spaceh, hearing Widend Behavioral Hearing Addendum attached. Hearing Addendum attached. Height Con Con Spaceh, hearing Widend Hearing Hearing Addendum attached. Height Con Con Spaceh, hearing Height Con Con Spaceh, hearing Hearing Addendum attached. Height Con Con Spaceh, hearing <																	
□ Complicated by		i i i i i i i i i i i i i i i i i i i												tent			
Altergies None Epi pen prescribed Anapphysis					Quick Relief Medication Inhaled Corticosteroid					Oral Steroid Other Controller None							
Competing in strain in the intervent of the interven			Anaphylaxis		🗌 Seiz	Seizure disorder											
Diabeties (attant MAP) Dither (step) Dither (step) Dither (step) Attach MAP in in-school medications needed Physical Exam WAL Kattach MAP in in-school medications needed Physical Exam WAL Weight kg (Congenital or acquired hea	er 🗌 Tub	□ Speech, hearing, or visual impairment □ Tuberculosis (latent infection or disease)				□ None □ Yes (list below)								
Provention of reference in the school medications needed PHYSICAL EXAM Date of Exam: / / Explain all checked items above. Physical Exam WNL M Adar					Hospitalization												
Other Result Ceneral Appearance: Height cm				🗌 Othe	er (specify) _	ached		-									
PHYSICAL EXAM Date of Exam: // / General Appearance: Height cm //// //// //// Weight kg //// //// //// //// BMI kg/m² //// //// //// ///// ///// BMI kg/m² ///// ///// ///// /////// /////// ///////////// ////////////////////////////////////																	
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Image: Sectal-Emotional or Other Area of Concern: Pestive: Sected Delay or Concern: Nutrition Dete Done Results Child Receives EVCPSE/CSE services Yes Not at risk Other Area of Concern: Image: Sectal-Emotional or Methods and on the past in t															ıl		
Biod Pressure (age 3 yrs) / Describe abnormalities: DEVELOPMENTAL (age 0-6 yrs) Nutrition Results Validated Screening Tool Used? Date Screened <1 year		(iiio) %ile)	🗆 🗆 Behavioral		Neck		-				-			-			
DEVELOPMENTAL (age 0-6 yrs) Nutrition Hearing Date Done Results Validated Screening Tool Used? Date Screened 1 year Breastfed Formula Both 4 years: gross hearing /// MN dahni Referred Yes No /// MN Both A Years: gross hearing //// MN dahni Referred Delay or Concern Suspected/Confirmed (specify area(s) below): SCREENING TESTS Date Done Results 3 years: Vision appears: /// NN dahni Referred Gonitwo/Problem Solving dataptive/Self-Help SCREENING TESTS Date Done Results 3 years: Vision appears: /// NN dahni Actify (required for new entrants and children age 3-7 years) // NN dahni Actify (required for new entrants and children age 3-7 years) Child Care Only Yes No Describe Suspected Delay or Concern: Lead Risk Assessment (annually, age 6 mo-6 yrs) ///// At risk (do BLJ) Screened with Glasses? Yes No Child Receives EVCPSE/CSE services Yes No Child Care Only yes Wes No Child Receives EVCPSE/CSE services Yes No		/0110/	Describe abnormalities:														
Validated Screening Tool Used? Date Screened year Breastfed Formula Both 2 Yes No /_/ Ni Abni Referred Dietary Restrictions None Yes No /_/ Ni Abni Referred Dietary Restrictions None Yes No / Ni Abni Referred Dietary Restrictions None Yes No / Ni Abni Referred Dietary Restrictions None Yes No Abni Referred Dietary Restrictions None Yes No Abni Referred Screening Results Screening Tool Used? Screening Results Screening Tool Used? Ni Abni Constitive/Proben Solving Gotte Area of Concern: Screening Tool (ELL) / Use Screening Results Screened with Glasses? Ni Ni Abni Blood Lead Level (BLL) / Ni At risk (do BLL) Screened with Glasses? Yes No Screened with Glasses? Yes No		-	Nutrition					Hearing			Dat	te Done			Results		
□ Yes □ No / / / ≥ 1 year □ Well-balanced □ Needs guidance □ Counseled □ Referred Dietary Results: □ WNL □ OAE / / / □ / □ / □ / □ / □ / □ / □ / □ / □				mula 🗆	Both				s hearing	q	_	/	/	/	Nonl 🗌 Ref	erred	
Screening Results: WNL Delay or Concern Suspected/Confirmed (specify area(s) below): SCREENING TESTS Date Done Results Cognitive/Problem Solving Adaptive/SetF-Help SCREENING TESTS Date Done Results Social-Emotional or Other Area of Concern: Screened Vision J. / / µg/dL Acuity (required for new entrants and children age 3-7 years) / / µg/dL Describe Suspected Delay or Concern: Lead Risk Assessment (annually, age 6 mo-6 yrs) / _ / µg/dL Screened with Glasses? Yes No Child Receives El/CPSE/CSE services Yes No Hemoglobin or / _ / / / / / / / / / /	□ Yes □ No/_					Counseled 🗆	Referred			-	_	/	_/ [Nbnl 🗌 Ref	erred	
Cognitive/Problem Solving Adaptive/Self-Help SCREENING TESTS Date Done Results -3 years: Vision appears: /// Right /// Communication/Language Gross Motor/Fine Motor Biod Lead Level (BLL) /// /// /// /// /// Auity (required for new entrants and children age 3-7 years) /// /// Right /// Describe Suspected Delay or Concern: Lead Risk Assessment (annually, age 6 mo-6 yrs) //// //// /// ////	-				(IISt Delow)			\geq 4 yrs: pure ton	e audior	netry		_/	_/ []NI 🗆 4	Nbnl 🗌 Refe	erred	
Construct Tool Tools and performation of the Motor Construct Tool Tool Tool Tool Tool Tool Tool Too		s) below):	SCREENING TESTS	Date Don	le	Results	1		00000r0				, 1				
Social-Emotional or Personal-Social Other Area of Concern: (required at age 1 yr and 2 yrs and for those at risk)		tor .			/		µg/dL	-				/	/ F	Right	/		
Describe Suspected Delay or Concern: Lead Risk Assessment (annually, age 6 mo-6 yrs)				/	,	_	ug/dl					_/	_/ L				
Lead Hisk Assessment (annually, age 6 mo-6 yrs) / _ / _ / /			,	/_	/	 □ At ris		Screened with G	lasses?								
Immunizations – DATES				/ Strabismu			Strabismus?										
Hemoglobin or Hematocrit /		ŀ		Child Car	e Onlv ——	Not a			cav					i r	Ves [] No	
Clinic Receives EI/CPSE/CSE services Yes No Report only positive immunity: CIR Number Immunity Physician Confirmed History of Varicella Infection Report only positive immunity: IMMUNIZATIONS – DATES IgG Titers Date DTP/DTaP/DT /_/_/ /_//_/ ////////////////////////////////////		ľ			· · · ·					eferral ((pain, s	welling	, infection)	*			
IMMUNIZATIONS - DATES IgG Titers Date DTP/DTaP/DT /_/_////////	Child Receives EI/CPSE/CSE services	∕es □ No	Hematocrit	/	/	-	%	Dental Visit with	in the pa	ast 12	months	S			Yes 🗆] No	
DTP/DTaP/DT /_/_/_ /_//_ /_//_ /_//_ /_//_ Hepatitis B /_/_/_ Td /_/_/_ /_//_ /_//_ /_//_ MMR /_/_/_ /_//_ Measles /_/_/_ Polio /_//_ /_//_ /_//_ /_//_ Varicella /_//_ /_//_ Mumps /_/_/	CIR Number		Pr	nysician C	confirmed His	story of Vari	cella Infectio	on 🗌					Report or	ıly posit	ive immun	ity:	
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ASSESSMENT URIL Child (Z00.129) Diagnoses/Problems (list) ICD-10 Code RECOMMENDATIONS Full physical activity	ASSESSMENT URl (Z00.129)	🗌 Diagno	oses/Problems (list) ICI	D-10 Cod	e RECOMN	IENDATION	S □ Fu	ll physical activity	r								
					-												
Follow-up Needed No Yes, for Appt. date: // Referral(s): None Early Intervention IEP Dental Vision						•					Dont			:/_	/		
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Health Care Practitioner Signature Date Form Completed DOHMH PRACTITIONER DOHMH PRACTITIONER DOHMH DOH	Health Care Practitioner Signature						Completed	/ /	D		PRA	CTITIO	NER				
Health Care Practitioner Name and Degree (print) Practitioner License No. and State TYPE OF EXAM: NAE Current NAE Prior Year(s	Health Care Practitioner Name and Degree (print)					cense No. a	ind State	` `	T۱	(PE OF	EXAM	1: 🗆 N	IAE Current	□ NA	E Prior Yea	ar(s)	
Facility Name National Provider Identifier (NPI) Date Reviewed: I.D. NUMBER	Facility Name		N	National Provider Identifier (NPI)													
Address City State Zip // / REVIEWER: / / / / /	Address	City	ę	State Zip													
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