CHILD & ADOLESCENT HEALTH EXAMINATION FORM
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE – DEPARTMENT OF EDUCATION

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name ___________________________ First Name ___________ Middle Name ___________

Sex □ Female □ Male Date of Birth (Month/Day/Year) __ / __ / ______

Child's Address ____________________________________________

City/Borough State Zip Code __________________________________

Health insurance □ Yes □ No Parent/Guardian Last Name ___________ First Name ___________

Health care provider signature ____________________________

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

Birth history (age 0-6 yrs)

□ Uncomplicated □ Premature: ________ weeks gestation □ Complicated by ____________________________

Allergies □ None □ Epi pen prescribed

Drugs (list) __________________________________________

Foods (list) __________________________________________

Other (list) __________________________________________

Blood Pressure (age 0-3 yrs) ____________________ / __________

Height __________ cm ( ______ %ile) Weight __________ kg ( ______ %ile) BMI __________ kg/m² ( ______ %ile)

Head Circumference (age <2 yrs) __________ cm ( ______ %ile)

Physical Examination

General Appearance:

□ Normal □ SI □ EWS □ Other:

Describe abnormalities: ____________________________

Screening Tests

Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) __________ μg/dL

Date Done Results ____________________________

Lead Risk Assessment (annually, age 6 mo-6 yrs) __________ μg/dL

Date Done Results ____________________________

Hearing

□ Normal □ Abnormal

Date Done Results ____________________________

Hemoglobin or Hematocrit (age 9-12 mo) __________ g/dL __________ %

Date Done Results ____________________________

IMMUNIZATIONS – DATES

Date of Birth

Child & Adolescent Health Examination Form

Middle Name

To Be Completed by Parent or Guardian

Date

Location

Parent/Guardian

Date

Address

City

State

Zip

Sex

Female

Male

To Be Completed by Health Care Provider

Date Done

Results

Other, specify:

□ Uncomplicated □ Premature: ________ weeks gestation □ Complicated by ____________________________

Allergies

□ None □ Epi pen prescribed

Drugs (list)

Foods (list)

Other (list)

Physical Examination

General Appearance:

□ Normal □ SI □ EWS □ Other:

Describe abnormalities: ____________________________

Screening Tests

Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) __________ μg/dL

Date Done Results ____________________________

Lead Risk Assessment (annually, age 6 mo-6 yrs) __________ μg/dL

Date Done Results ____________________________

Hearing

□ Normal □ Abnormal

Date Done Results ____________________________

Hemoglobin or Hematocrit (age 9-12 mo) __________ g/dL __________ %

Date Done Results ____________________________

Immunizations – Dates

Hep B __________ Rotavirus __________ DTP/DTaP __________ Hib __________ PCV __________

Other __________

Recommendations

□ Full physical activity □ Full diet

□ Follow-up Needed □ No □ Yes, for ____________________________ Appt. date: __ / __ / ______

□ Other

□ Referral(s): □ None □ Early Intervention □ Special Education □ Dental □ Vision

□ Other

Health Care Provider Signature ____________________________

Date

DOHMH ONLY Provider I.D.

□ White School/Child Care/Early Intervention/Center/Work

□ Canary Health Care Provider

□ Pink Parent/Guardian

Date

Reviewed

I.D. Number

REVIEWER:

Provider License No. and State

National Provider Identifier (NPI)

Address

Date

Comments

Type of Exam:

□ NAE Current □ NAE Prior Year(s)

Copy: White

School/Child Care/Early Intervention/Center/Work

Canary

Health Care Provider

Pink Parent/Guardian

Date

□ Full physical activity □ Full diet

□ Follow-up Needed □ No □ Yes, for ____________________________ Appt. date: __ / __ / ______

□ Other

□ Referral(s): □ None □ Early Intervention □ Special Education □ Dental □ Vision

□ Other