

Health Information Form
(front and back)

Student Name: _____
 Student Date of Birth: _____
 Address: _____
 Home Phone Number: _____
 Previous School: _____
 Legal Guardians: (Check One) ___ Both Parents ___ Mother ___ Father ___ Guardian
 Name(s) of Guardian(s): _____
 Guardian's Home Phone: _____
 Guardian's Work Phone: _____
 Guardian's Cell/Pager: _____
 In emergency, notify: _____
 Doctor/Health Center: _____
 Doctor's Phone Number: _____
 Doctor's Fax Number: _____
 Preferred Hospital: _____
 Health Insurance: _____
 Health Insurance Policy #: _____
 Name of Dentist: _____
 Allergies to Medication: _____
 Allergies to Food: _____

1. Do any of the student's family/household members have any major health problems? Yes No
 If yes, please describe:

2. Has the student had any of the following illnesses or conditions?

Accidents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G6PD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lead Poisoning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Behavioral Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Menstrual Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney/Urinary Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Learning Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear/Throat Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospitalizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone/Joint Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe in more detail, any of the above items that are marked 'Yes:'

3. Hearing / Vision / Speech

Has this student had convulsions or seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this student had a hearing test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student have a hearing problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student have a vision problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this student had a vision test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student wear glasses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes: ___ Full Time ___ Reading ___ Distance ___ Other		
Does this student receive preferential seating for a vision/hearing problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student receive speech therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe in more detail, any of the above items marked 'Yes:'

4. Does this student have any special needs that the school should be aware of? (For example, is it necessary to limit activity?)

5. Is this student taking any medication on a daily basis? Yes No

If yes, please specify:

6. Has the student had Chicken Pox Disease? Yes No

If yes, date of disease: _____

If yes, a physician certified history must be on file at the school.

Name of Parent/Guardian (please print)

Signature of Parent/Guardian

Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM <small>NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION</small>				<small>Please Print Clearly Press Hard</small> STUDENT ID NUMBER															
TO BE COMPLETED BY PARENT OR GUARDIAN																			
Child's Last Name		First Name		Middle Name															
Child's Address			Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____															
City/Borough		State	Zip Code	School/Center/Camp Name															
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent/Guardian <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		Last Name First Name		District Number _____ Phone Numbers Home _____ Cell _____ Work _____															
TO BE COMPLETED BY HEALTH CARE PROVIDER <i>If "yes" to any item, please explain (attach addendum, if needed)</i>																			
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 <small>If persistent, check all current medication(s):</small> <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) _____																	
<i>Explain all checked items above or on addendum</i>																			
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 style="width:100%; border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> HEENT</td> <td style="border: none;"><input type="checkbox"/> Lymph nodes</td> <td style="border: none;"><input type="checkbox"/> Abdomen</td> <td style="border: none;"><input type="checkbox"/> Skin</td> <td style="border: none;"><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Dental</td> <td style="border: none;"><input type="checkbox"/> Lungs</td> <td style="border: none;"><input type="checkbox"/> Genitourinary</td> <td style="border: none;"><input type="checkbox"/> Neurological</td> <td style="border: none;"><input type="checkbox"/> Language</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Neck</td> <td style="border: none;"><input type="checkbox"/> Cardiovascular</td> <td style="border: none;"><input type="checkbox"/> Extremities</td> <td style="border: none;"><input type="checkbox"/> Back/spine</td> <td style="border: none;"><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____			<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"/> 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 style="width:100%; border: none;"> <tr> <th style="border: none;">Date Done</th> <th style="border: none;">Results</th> </tr> <tr> <td style="border: none;"> Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small> _____ / _____ _____ μg/dL </td> <td style="border: none;"> _____ μg/dL </td> </tr> <tr> <td style="border: none;"> Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small> _____ / _____ </td> <td style="border: none;"> <input type="checkbox"/> At risk (w/ BLL) <input type="checkbox"/> Not at risk </td> </tr> <tr> <td style="border: none;"> Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE _____ / _____ </td> <td style="border: none;"> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal </td> </tr> <tr> <td colspan="2" style="border: none; text-align: center;">Head Start Only</td> </tr> <tr> <td style="border: none;"> Hemoglobin or Hematocrit (age 9-12 mo) _____ / _____ </td> <td style="border: none;"> _____ g/dL _____ % </td> </tr> </table>			Date Done	Results	Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small> _____ / _____ _____ μg/dL	_____ μg/dL	Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small> _____ / _____	<input type="checkbox"/> At risk (w/ 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	Head Start Only		Hemoglobin or Hematocrit (age 9-12 mo) _____ / _____	_____ g/dL _____ %			
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Tuberculosis <small>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</small> 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 Vision (required for new school entrants and children age 4-7 yrs) <input type="checkbox"/> with glasses Acuity Right _____ / _____ Left _____ / _____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes																			
IMMUNIZATIONS - DATES CIR Number of Child _____ Hep B _____ / _____ Rotavirus _____ / _____ DTP/DtaP/DT _____ / _____ Hib _____ / _____ PCV _____ / _____ Polio _____ / _____		Influenza _____ / _____ MMR _____ / _____ Varicella _____ / _____ Td _____ / _____ Tdap _____ / _____ Hep A _____ / _____ Meningococcal _____ / _____ HPV _____ / _____ Other, specify: _____ / _____																	
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 _____ _____ _____																	
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) Comments _____															
Facility Name		National Provider Identifier (NPI)		Date Reviewed: _____ / _____ / _____ I.D. NUMBER _____															
Address		City		State															
Zip		Telephone (_____) _____ - _____		Fax (_____) _____ - _____															
REVIEWER: _____																			