**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**: [Blank]
- **First Name**: [Blank]
- **Middle Name**: [Blank]
- **Sex**: [Male]
- **Date of Birth (Month/Day/Year)**: [Blank]
- **Hispanic/Latino?**: [Yes]
- **Race**: [American Indian/Black]
- **Health Insurance**: [Yes]
- **State**: [Blank]
- **Zip Code**: [Blank]
- **School/Camp Name**: [Blank]
- **Health Care Provider**: [Blank]
- **Health Care Provider Name**: [Blank]
- **Medical History**: [Blank]
- **Blood Pressure**: [Blank]
- **BMI**: [Blank]
- **Head Circumference**: [Blank]
- **Blood Lead Level (BLL)**: [Blank]
- **Lead Risk Assessment**: [Blank]
- **Hearing**: [Blank]
- **Hemoglobin**: [Blank]
- **Immunizations**: [Blank]
- **RECOMMENDATIONS**: [Blank]
- **Follow-up Needed**: [Blank]
- **Referral(s)**: [Blank]
- **Health Care Provider Signature**: [Blank]
- **Provider License No. and State**: [Blank]
- **Facility Name**: [Blank]
- **National Provider Identifier (NPI)**: [Blank]
- **Telephone**: [Blank]
- **Fax**: [Blank]

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**TO BE COMPLETED BY HEALTH CARE PROVIDER**

If "yes" to any item, please explain (attach addendum, if needed)

- **Birth History**: [Uncomplicated] [Premature] [Complicated]
- **Allergies**: [None] [Epi pen prescribed]
- **Drugs**: [Yes]
- **Food**: [Yes]
- **Blood Pressure**: [Blank]
- **BMI**: [Blank]
- **Head Circumference**: [Blank]
- **Blood Lead Level (BLL)**: [Blank]
- **Lead Risk Assessment**: [Blank]
- **Hearing**: [Blank]
- **Hemoglobin**: [Blank]

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**PHYSICAL EXAMINATION**

- **Height**: [Blank] cm
- **Weight**: [Blank] kg
- **BMI**: [Blank] kg/m²

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**DEVELOPMENTAL**

- **Height**: [Within normal limits]
- **Weight**: [Within normal limits]
- **BMI**: [Within normal limits]

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**SCREENING TESTS**

- **Blood Lead Level (BLL)**: [Blank] μg/dL
- **Lead Risk Assessment**: [At risk] [Not at risk]
- **Hearing**: [Normal] [Abnormal]
- **Head Start Only**: [Yes]

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**IMMUNIZATIONS — DATES**

- **Hep B**: [Blank]
- **Rotavirus**: [Blank]
- **DTp/DtAp/DT**: [Blank]
- **Hib**: [Blank]
- **PCV**: [Blank]

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**RECOMMENDATIONS**

- **Full physical activity**: [Yes]
- **Full diet**: [Yes]

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**ASSESSMENT**

- **Well Child (W/2.0)**: [Yes]
- **Diagnoses/Problems (V19)**: [Blank]

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**DISCHARGE ONLY**

- **Provider I.D.**: [Blank]
- **Type of Exam**: [Blank]
- **Comments**: [Blank]

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**REVIEWER**: [Blank]