CHILD & ADOLESCENT HE NYC DEPARTMENT OF HEALTH & MENTAL HYC	EALTH	H EXAMIN - DEPARTMENT	ATION OF EDUCAT	FO	RM Ple Print Cle	ease early	NYC ID (OSIS)							
TO BE COMPLETED BY THE PA	RENT	OR GUARDI								•				
Child's Last Name	First Name			Middle Name	Middle Name			Sex				ear)		
Child's Address				Hispanic/Latino		lace (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other					Э			
City/Borough	State	Zip Code	S	ichool/	Center/Camp Name				District Number		Phone Num Home			_
Health insurance Yes Parent/Guardian (including Medicaid)? No Foster Parent	Last Name	ne First Name				ail				Cell				
TO BE COMPLETED BY THE HEALT	TH CAR	E PRACTITIO	NER			i								
Birth history (age 0-6 yrs)	ļ	Does the child/ad				· · · · · · · · · · · · · · · · · · ·	к							
☐ Uncomplicated ☐ Premature: weeks ges	tation	Asthma (check severity and attach MAF): Intermittent If persistent, check all current medication(s): Quick Relief Medica					☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None							
Complicated by		Asthma Control St Anaphylaxis	atus		☐ Well-controlled☐ Seizure disorde		Poorly Controlled or			L 888F :4	:b1		df)	
Allergies None Epi pen prescribed		☐ Behavioral/mental	Speech, hearin	Speech, hearing, or visual impairment				Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)						
☐ Drugs (list)		Congenital or acquDevelopmental/lea	rning problen	soraer n	☐ Tuberculosis (latent infection or disease) ☐ Hospitalization									
☐ Foods (list)	[☐ Diabetes <i>(attach M</i> ☐ Orthopedic injury/o	<i>AF)</i> disability		☐ Surgery ☐ Other (specify)			_						
☐ Other (list)		Explain all checked	items above).	☐ Addendum at			-						
Attach MAF in in-school medications needed														
PHYSICAL EXAM Date of Exam:/_	/(General Appearance		□ Dhua	cal Exam WNL									
Height cm (%ile)	NI Abnl		⊒ PHySi <i>II Abnl</i>	cai exaiii wine	NI Abni		NI Abnl		1	NI Abnl			
Weight kg (□ □ Psychosocial De		□ HE	ENT	☐ ☐ Lympl			odomen		□ □ Skin			
BMIkg/m² (/0110/	☐ ☐ Language				Lungs			enitourinary		☐ ☐ Neuro			
Head Circumference (age ≤ 2 yrs) cm (%ila\ ⊢	□ □ Behavioral Describe abnormali		□ Ne	eck	☐ ☐ Cardio	ovascular	<u> </u>	tremities		☐ ☐ Back	spine		
Blood Pressure (age ≥3 yrs) /														
DEVELOPMENTAL (age 0-6 yrs)		Nutrition					Hearing		Dat	te Done	,	Res	sults	
S		< 1 year □ Breastfeo ≥ 1 year □ Well-bala				Referred	< 4 years: gros	s hearing	g	_/		VI □Abr		
☐ Yes ☐ No/_ Screening Results: ☐ WNL		Dietary Restrictions				noionea	OAE		_	_/		VI □Abr		
☐ Delay or Concern Suspected/Confirmed (specify area(s) below):			≥ 4 yrs: pure tone a Vision				te Done	<i>/</i>	VI □Abr	nl ∐Re sults	erred		
☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help		SCREENING TESTS Date Done			Result	Results <3				/	/	□ NI		า/
☐ Communication/Language ☐ Gross Motor/Fine Motor ☐ Social-Emotional or ☐ Other Area of Concern:		Blood Lead Level (BLL) (required at age 1 yr and 2			/	Acuity (required			,	Rig _/ Lef	ht	_		
Personal-Social United Area of Concern		yrs and for those at risk)/			/	and children ag	e 3-7 yea	irs) —			Unab	le to te	est	
Describe Suspected Delay or Concern:		Lead Risk Assessment (annually, age 6 mo-6 yrs) ———————————————————————————————————			☐ At ri	sk <i>(do BLL)</i>	,				☐ Yes ☐ No			
					/ Not :	at risk	Strabismus? Dental				☐ Yes	N	10	
					Only ——		Visible Tooth Decay					`	Yes	☐ No
					,	g/dL	Urgent need for Dental Visit with				n, infection)			□ No
	es 🗆 No	Hematocrit				%		iiii uie pa	451 12 1110111118		December 1			
CIR Number			Pnysici	ian Cor	firmed History of Var	icelia intectio	on 🗀				Report only	positive	e immu	mity:
IMMUNIZATIONS – DATES					•						IgG Titer	s Date	!	
DTP/DTaP/DT/////	_//	//	/	./	//	1	Гdар/	_/	/	/	Hepatitis		./	
Td/////	_//	//	/	./	MMR _ Varicella	//_	/	_'	/	./	Measle		.//	<u>'</u> —
Hep B / / / /	_//_	//	/	/	Varicella _ Mening ACWY	//	/	-'	/	/	Mump Rubell		.//	,
Hib / / / /	_		/	/	Hep A			-'	/	/	Varicell		//	
PCV/////	_//_	//	/	/	Rotavirus	//_	/	_/	/	/	Polio		/	/
Influenza / //	_//_	//	/	/	Mening B	//	/	_/	/_	/	Polio	2	/	/
HPV///////	_//		/	/	Other	/_	/		/	./	Polio	3	/	/
ASSESSMENT Well Child (Z00.129)	□ Diagnos	ses/Problems (list)	ICD-10	Code	RECOMMENDATION		ıll physical activit	у						
					Restrictions (spec									
					Follow-up Needed				Dont		Appt. date: _	/	/_	
					Referral(s):	ione LE	arry milervemuofi		P ☐ Denta	ai 🗀	Vision			
Health Care Practitioner Signature					Date Form	Completed	/ /		OHMH PRAC	CTITION	ER	П		
Health Care Practitioner Name and Degree (print)				Practitioner License No. and State			TY	TYPE OF EXAM: NAE Current NAE Prior Year(s) Comments:						
Facility Name					National Provider Identifier (NPI)									
Address				Ctoto 7:n				Da	Date Reviewed: I.D. NUMBER					
Address City					State	Zip		RE	/ Eviewer:	- /	- []			
Telephone	Fax				Email			FC	DRM ID#	1		—		