CHILD & ADOLI	ESCENT I	HEALT HYGIENE	H	EXAMINATION DEPARTMENT OF EDU	N F	OF N	RM Pla Print Cla	ease early	NYC ID (OSIS)								
TO BE COMPLETE	D BY THE	PAREN	T OI	R GUARDIAN		123							. 11			1	'n
Child's Last Name			First Name				Middle Nam		Sex	☐ Female	Date	of Birth	(Month	¹v/Day/Y	rear)		
Child's Address			-				Hispanic/Latin		(Check ALL that appl)		American In		☐ Asian	□ Bla	ack [□ Whi	te
City/Borough State			Zip Code School/Co			ol/Ce	nter/Camp Name	are riziralish don	Dist Num				Phone Numbers Home				
Health insurance Yes Parent/Guardian Last Nac			me First Name			Ema			nail		Cell						
(including Medicaid)? No	☐ Foster Parent												Work_				
TO BE COMPLETED	BY THE HEA	LTH CA			U ,-	19							Tra-				
Birth history (age 0-6 yrs)				s the child/adolescent sthma (check severity and a					tory of the follow Mild Persistent		Moderate Per	reigtant	П	overe [Doreiet	ont	
☐ Uncomplicated ☐ Premature: weeks gestation			If persistent, check all current medication(s):			(s): [☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller						□ Nor				
Complicated by				ethma Control Status naphylaxis			■ Well-controlled ■ Seizure disorde		Poorly Controlled or N		olled i cations <i>(atta</i>	ach MAE	if in cohoo	l modi	leation	noodod	
Allergies None Epi pen pre	escribed		III B	ehavioral/mental health dis	t dicorda	[🗌 Speech, hearin	ig, or visual	impairment	□ N			Yes (list			neeueu,	
□ Drugs (list)				evelopmental/learning prol abetes <i>(attach MAF)</i>	[☐ Hospitalization											
☐ Foods (list)			□ Orthopedic injury/disability				☐ Surgery ☐ Other (specify)										
☐ Other (list)			Expla	ain all checked items ab	ove.		Addendum at	tached.		-				—			_
Attach MAF if in-school medica										1-							
	Date of Exam:	-''-	Gene	eral Appearance:	□ Ph	vsical	Exam WNL	:::::::::::									
Heightcm		%ile)	NI AL		NI Abi	•		Ni Abni	į.	Ni Abni			Ni Abni				
Weightkg	,	%lle)	_	Psychosocial Development				☐ ☐ Lymp			odomen		□□s				
BMIkg/n	,	%ile)		Language Behavioral				Lung			enitourinary ctremities						
Head Circumference (age ≤2 yrs) _	cm (%ile)	Desc	ribe abnormalities:											,,,,,,		
Blood Pressure (age ≥3 yrs)	/		Nutri	4					Tax .								
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used?	Dai	te Screened	A 140 HO A	oon ear 🗆 Breastfed 📋 Form	nula 🗇	Roth			Hearing	. booda		ate Done				sults	
☐ Yes ☐ No				ear 🗌 Well-balanced 🗌 N	uidand		1			_/_				ni □R ni □R			
Screening Results: WNL				ry Restrictions None	(list be	elow)					/_	- 1			ni 🗆 R		
☐ Delay or Concern Suspected/Co	dening the special contract and the second	a(s) below):	CCD	EENING TECTO	Dala Don		Danielle		Vision			ate Done				sults	,,,,,,,,,
Cognitive/Problem Solving Adaptive/Self-Help Communication/Language Gross Motor/Fine Motor			SCREENING TESTS Date Done Blood Lead Level (BLL)			Results <3 years: Vision ap					_/_	J		□ <i>NI</i> t	☐ Ab	nl	
Social-Emotional or	Other Area of Conc		(requ	ired at age 1 yr and 2	′-		<u>/</u>		Acuity (required and children age			_/_	1	Left		_′_	
Personal-Social Describe Suspected Delay or Con-	cem·			nd for those at risk)		_	/	μg/dL sk (do BLL)	Corporad with C				į			ole to t	
Booking Coopering Stray of Confe				Risk Assessment vally, age 6 mo-6 yrs)	/_		/	. ,	Screened with G Strabismus?	iasses?					☐ Yes ☐ Yes		
			(4,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1		ild Con	o Only	☐ Not a	at risk	Dental								
			— Child Care On Hemoglobin or			g/dL			Visible Tooth Decay Urgent need for dental referral (pain, sw.			swalling	☐ Yes ☐ ☐ Yes ☐ ☐ Hing, infection ☐ Yes ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Child Receives EI/CPSE/CSE servic	ces 🗆	Yes 🗆 No		atocrit -	/_		/	%	Dental Visit withi				, whocoon	1		Yes	
CIR Nu			П	Phy	sician C	onfirm	ned History of Vari		on 🗆				Report	only p	oositiv	e imm	unity:
IMMUNIZATIONS – DATES													loG 1	liters	Date	,	
DTP/DTaP/DT//	/	//_		_/_/_	/		_//_		Tdap/	/	/_	/	Hepat	-		1.	/
Td/	//	//_			_/	2	MMR	//_		/	/_	_/		asles		/	/
Polio//	//	//_		///////////////	/	-	Varicella		/	<u>/</u>	/_	_/	Mu	umps	_	/	/
Hep B//	//	//_		////	_/_	_ N	fening ACWY	//_	/	/	/	_/	Ru	ibella	_	/	/
Hib//	_//	''		''	_/	-	Hep A _	//_	/		/_	_/		icella	_	./	
Influenza / /	//	//_		''	/	-	Rotavirus _ Mening B	//_		/	/	_/	1	olio 1 olio 2		./	<u>'</u> —
HPV / /	1 1	1 1		1 1 1	<i>y</i>	Oth	her	''		_		_/	1	olio 3		/	
ASSESSMENT	ild (Z00.129)	☐ Diagno	ses/P	roblems (list) ICD-	10 Code	-	COMMENDATION	S □ Fi	ull physical activity				1				_
XIIIIIII	WHILE BITTS 200000						Restrictions (speci	fy)		111			***************************************				_
						1			Yes, for				Appt. dat	ie:	_/_	/_	
						1	lerral(s): 🗌 No	one 🗆 E	arly Intervention		Dent 🗆 Dent	tal [Vision				
lealth Care Practitioner Signature						I'''	Other Date Form C	Completed	, ,	DO	DHMH PRA	CTITION	ŒR		Ŧ	T	T
Health Care Practitioner Name and	Degree (print)				Pra	actitio	ner License No. a	nd State		TY	NLY I.D. PE OF EXAM	A: □ N	AE Currer	nt 🗆) NAE	Prior Y	ear(s)
acility Name					Na	itional	Provider Identifie	r (NPI)			mments:		I.D. N	IIMO	ED	5	Š
Address				City		State Zip			1.0	/							
elephone		Fax				E	Email				VIEWER:		TT	T		_	T
Market and the second s	***************************************	1										ш					ш