

Please return this form to Ms. Petruso by June 30, 2017

GENERAL RELEASE

I hereby authorize Garden School, to use photographs of my child,
_____, in its publications, advertising and
on the Garden School website (www.gardenschool.org).

Parent or Guardian Signature

Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other			
City/Borough	State	Zip Code	School/Center/Camp Name			District Number	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name		Email		Cell _____ Work _____

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

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) _____ Attach MAF in in-school medications needed		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Asthma Control Status: <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.					
		Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

PHYSICAL EXAM Date of Exam: ____/____/____ 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: <input type="checkbox"/> Physical Exam WNL <table border="0"> <tr> <td><input type="checkbox"/> Psychosocial Development</td> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> Lymph nodes</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Language</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> </tr> <tr> <td><input type="checkbox"/> Behavioral</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/> Back/spine</td> </tr> </table>						<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin																		
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<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine																		
		Describe abnormalities:																				

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		Hearing Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern: _____		SCREENING TESTS Date Done ____/____/____ Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) _____ μg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Vision Date Done ____/____/____ Results < 3 years: Vision appears: _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right _____ Left _____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives E/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Hemoglobin or Hematocrit _____ g/dL _____ %		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
IMMUNIZATIONS - DATES				IgG Titers Date	
DTP/DTaP/DT	Tdap	MMR	Hepatitis B	_____	
Polio	Varicella	Mening ACWY	Measles	_____	
Hep B	Hep A	Rotavirus	Mumps	_____	
Hib	Mening B	Other	Rubella	_____	
PCV			Varicella	_____	
Influenza			Polio 1	_____	
HPV			Polio 2	_____	
			Polio 3	_____	

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <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"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature	Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments:
Address	City	Date Reviewed: ____/____/____ I.D. NUMBER _____
Telephone	Fax	REVIEWER: _____
	Email	FORM ID# _____