CHILD & ADOLESCENT HEA				FOR	Prin	Please t Clearly ess Hard	STUDENT ID	NUMBE OSI							
TO BE COMPLETED BY PARENT OR GUARDIAN															
Child's Last Name	First Name				Middle Name					Sex					
Child's Address		Hispanic/Latino? Race (Check ALL that apply) American Indian													
City/Borough State Zip Code Sc			School/Center/	Center/Camp Name ill Basin Day Cam					District Phone Numbers Number Home						
Health insurance				First Name				Cell							
TO BE COMPLETED BY HEALTH C	ARE PR	OVIDER	If "yes"	to an	y item	, pleas	e explain	(attac	h adde	endum,	if nee	ded)		
Birth history (age 0-6 yrs) Does the child/adolescent have a past or present medical history of the followin Asthma (check severity and attach MAF/Asthma Action Plan): Intermittent Mild										\\	. O D-		A. C.		
): 🗌 Inha	aled cortico	osteriod 🗌	Other controller	ller 🔲 Quick relief med 🔲 Oral steroid 🗀 None							
Allergies ☐ None ☐ Epi pen prescribed	☐ Chron	nacuvity bisorde otitis media d heart disorder	s media					Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)							
☐ Drugs (list)	ilist) □ Developmental/learning p □ Diabetes (attach MAF)				problem										
☐ Foods (list)	Diabe	les (allach MAr)		Other (specify)				Dietary Restrictions							
Other (list)				cked iten	ns above o	or on adden	ndum	☐ None ☐ Yes (list below)							
HYSICAL EXAMINATION General Appearance:					ked items above or on addendum				SERVICE CONTROL SERVICE CONTRO	THE PROPERTY OF THE PARTY OF TH	THE SECOND PROPERTY OF		Representative statements		
Heightcm (bnl	NI Abni		N	l Abnl					
Weightkg (%ile)	☐☐☐HEE		Lungs Genitouring				1					t		
BMIkg/m² (Cardiovascular					ne 🗀	☐ Behav	ioral						
Head Circumference (age ≤2 yrs)cm (%ile)	Describe abno	ormanues:												
Blood Pressure (age ≥3 yrs) / /						SECURIOR CONTRACTOR SOCIETA	7		_						
DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits	SCREENING '		Date D	Date Done Results						ate Done		sults			
If delay suspected, specify below	Blood Lead I (required at age	.evel (BLL) a 1 yr and 2 yrs	/	/µg/			Tuberculosis	Only requirements who have	red for studen not previously	nts entering inte y attended any l	mediate/midd IYC public or p	le/junior i rivate sc	or high school hool		
Cognitive (e.g., play skills)	and for those a	t risk)	/			μg/dL	PPD/Mantoux placed		/_		Induration	on	mm		
Communication/Language	Lead Risk As (annually, age 6		/	//		sk <i>(do BLL)</i> at risk	PPD/Mantoux read		NOTICE AND DESCRIPTION OF THE PERSON OF THE	/	□ Neg		Pos		
☐ Social/Emotional	Hearing Pure tone	audiometry				nal	Interferon Test Chest x-ray				☐ Neg		□ Pos		
Adaptive/Self-Help	□ OAE			// Abnormal			(if PPD or Interfero					cated			
	Hemoglobin	Head Star	t Only	Ī	g/dL Visi		Vision				Acuity Right /				
☐ Motor	Hematocrit (/	/		%	(required for new so and children age 4-			h glasses		Left			
IMMUNIZATIONS – DATES CIR Number of Child	1 1	1 1	1 1	Influ	ienza		1	1	1	1	1	1			
Hep B//////									/_	/	/_	/_			
Rotavirus/////////_				/ Varicella											
DTP/DTaP/DT////////			//	/ Td/_											
Hib				/ Tdap//					Hep A						
PCV//////////				/ Meningococcal/ /_ HPV /					/_	/	1	1			
Polio///////				/ Other, <i>specify</i> :/						er strengers (arminal transcen	/_	/_			
RECOMMENDATIONS					ASSESSMENT										
☐ Restrictions (specify)															
Follow-up Needed															
Referral(s): None Early Intervention Special	al Education	☐ Dental	☐ Vision							***************************************					
☐ Other								widowy in the second				-			
Health Care Provider Signature				Date / /					DOHMH PROVIDER I.D.						
Health Care Provider Name and Degree (print)				Provider License No. and State						NAE Curre	ent N	IAE Pri	or Year(s)		
Facility Name				National Provider Identifier (NPI)											
Address City				State Zip					Date I.D. NUMBER Reviewed:						
Telephone ()								REVIEWER	' :	_/L					