

NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE — DEPT. OF EDUCATION
Return in 2 Weeks. Please Print Clearly / Press Hard

HEALTH MESSAGE

STUDENT ID # / OSIS

See Reverse Side

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME			FIRST NAME			MIDDLE			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		BIRTHDAY MONTH DAY YEAR			RACE/ETHNICITY <i>Check all that apply</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Other			
<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT			LAST NAME			FIRST NAME			STUDENT ADDRESS			APT./FL. _____ ZIP _____			TELEPHONE NO. HOME: () _____ WORK: () _____		
SCHOOL			DISTRICT		NUMBER		<input type="checkbox"/> Public Elem <input type="checkbox"/> Public H.S. <input type="checkbox"/> Public JHS/IS <input type="checkbox"/> Non-Public		SCHOOL NAME:			<input type="checkbox"/> Annex 1 <input type="checkbox"/> Annex 2		Does this child have any form of health insurance, including Medicaid or Child Health Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

If yes to any item, provide:

Does the student have a past or present medical history of the following:

PRES.	PAST	NO	Item	PRES.	PAST	NO	Item	PRES.	PAST	NO	Item	DATE	DETAILS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA (If present, attach medication administration form)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (If present attach medication administration form)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Accidents	_____	_____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Problems/Limitations	_____	_____

PHYSICAL EXAMINATION: HEIGHT _____ in (%/o ile) WEIGHT _____ lb (%/o ile) BMI _____ (%/o ile) BLOOD PRESSURE _____ / _____

GENERAL APPEARANCE (NUTRITIONAL STATUS): _____

NL	AB	Item	NL	AB	Item	NL	AB	Item	NL	AB	Item
<input type="checkbox"/>	<input type="checkbox"/>	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	LYMPH NODES	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	BACK
<input type="checkbox"/>	<input type="checkbox"/>	DENTAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	GENITO URINARY	<input type="checkbox"/>	<input type="checkbox"/>	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	NECK	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	NEURO
									<input type="checkbox"/>	<input type="checkbox"/>	GROSS MOTOR
									<input type="checkbox"/>	<input type="checkbox"/>	PSYCHO/SOCIAL DEV.
									<input type="checkbox"/>	<input type="checkbox"/>	LANGUAGE
									<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL
									<input type="checkbox"/>	<input type="checkbox"/>	FINE MOTOR

DESCRIBE ABNORMALITIES: _____

Hearing		DATE	RESULTS	Vision		FAR		NEAR		FUSION		Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test.
AUDIO/SWEEP	_____	_____	P F	Right	____/____	____/____	____/____	____/____	P F			
THRESHOLD	_____	_____	P F	Left	____/____	____/____	____/____	____/____	P F			
				Both	____/____	____/____	____/____	____/____				

TB: Only required for students newly entering the NYC school system in Intermediate/Middle/Junior or High School

MANTOUX			DATE	RESULTS	Chest X-ray			BCG	On INH
(PPD) IMPLANTED	_____	<input type="checkbox"/> NEGATIVE	_____	MM	DATE	_____	_____	_____	_____
READ	_____	<input type="checkbox"/> POSITIVE	_____	MM	RESULTS	<input type="checkbox"/> Normal	<input type="checkbox"/> YES	<input type="checkbox"/> YES	
						<input type="checkbox"/> Abnormal	<input type="checkbox"/> NO	<input type="checkbox"/> NO	
						<input type="checkbox"/> Not Indicated			

LEAD: Risk Assessment _____ DATE DONE _____ RESULTS No Risk At Risk If at risk, do venous lead screening DATE DONE _____ RESULTS _____

IMMUNIZATION — DATES

Citywide Immunization Registry no. _____

DPT/DTaP or DT or Td	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Other	____/____/____
IPV/OPV	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____		
Hepatitis B	____/____/____	____/____/____	____/____/____	MMR	____/____/____		
HIB	____/____/____	____/____/____	____/____/____	VZV	____/____/____		

May provide copy of CIR print out in lieu of completing this section. Must complete CIR Number above.

DIAGNOSES — If Asthma, indicate severity

<input type="checkbox"/> Well Child V202	ICD CODE	DATE OF EXAM: _____	DOH ONLY	PROVIDER I.D. _____
1. _____	____/____/____	MONTH DAY YEAR	TYPE OF EXAMINATION: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year/s	
2. _____	____/____/____		Comments	
3. _____	____/____/____		Date Reviewed: _____ I.D. NUMBER _____	
RECOMMENDATIONS/REFERRALS		Physician Signature	REVIEWER: _____	
<input type="checkbox"/> FULL PHYSICAL ACTIVITY <input type="checkbox"/> RESTRICTIONS Specify limitations and/or special alerts (i.e. allergies, medications, precautions)		Physician Name (Print)		
		Address		
		Telephone		
		Name of facility		
		Type of facility	<input type="checkbox"/> HHC Child Health Clinic <input type="checkbox"/> Private Practice <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> HHC Communicare Clinic <input type="checkbox"/> Comm. Health Center <input type="checkbox"/> OTHER <input type="checkbox"/> HHC Hosp. Clinic <input type="checkbox"/> Vol. Hosp. Clinic <input type="checkbox"/> SHP in School	