NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE — DEPT. OF EDUCATION

Return in 2 Weeks. Please Print Clearly / Press Hard

HEALTH MESSAG

STUDENT ID # / OSIS

See Reverse Side

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME | FIRST NAME | MIDDLE | SEX: 1 ☐ Male 2 ☐ Female | BIRTHDAY: MONTH DAY YEAR | RACE/ETHNICITY *Check all that apply*: ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ White ☐ Other

1 ☐ PARENT 2 ☐ GUARDIAN 3 ☐ FOSTER PARENT | LAST NAME | FIRST NAME | STUDENT ADDRESS | APT/FL | ZIP | TELEPHONE NO. HOME: ( ) WORK: ( )

SCHOOL DISTRICT NUMBER | 1 ☐ Public Elem 2 ☐ Public JHS/IS 3 ☐ Public H.S. 4 ☐ Non-Public | SCHOOL NAME: 07 ☐ Annex 1 08 ☐ Annex 2 | Does this child have any form of health insurance, including Medicaid or Child Health Plus? 1 2

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		PRES.	PAST	NO		PRES.	PAST	NO		DATE	DETAILS
☐	☐	☐	36 ASTHMA *(If present, attach medication administration form)*	☐	☐	☐	15 Diabetes *(If present attach medication administration form)*	☐	☐	☐	26 Speech Problems		
☐	☐	☐	12 Allergies					☐	☐	☐	31 Hospitalizations		
				☐	☐	☐	21 Cancer	☐	☐	☐	32 Surgery		
				☐	☐	☐	23 Orthopedic Problems	☐	☐	☐	33 Serious Illness		
☐	☐	☐	13 Congenital Heart Disease	☐	☐	☐	24 Vision Problems	☐	☐	☐	34 Serious Accidents		
☐	☐	☐	14 Seizures	☐	☐	☐	25 Hearing Problems	☐	☐	☐	35 Other Problems/Limitations		

PHYSICAL EXAMINATION: HEIGHT ______ in (%ile) WEIGHT ______ lb (%ile) BMI ______ (%ile) BLOOD PRESSURE ____/

GENERAL APPEARANCE (NUTRITIONAL STATUS): ______

NL	AB		NL	AB		NL	AB		NL	AB		NL	AB	
☐	☐	11 HEENT	☐	☐	14 LYMPH NODES	☐	☐	23 ABDOMEN	☐	☐	32 BACK	☐	☐	44 GROSS MOTOR
☐	☐	12 DENTAL STATUS	☐	☐	21 LUNGS	☐	☐	24 GENITO URINARY	☐	☐	33 SKIN	☐	☐	41 PSYCHO/SOCIAL DEV.
☐	☐	13 NECK	☐	☐	22 CARDIOVASCULAR	☐	☐	31 EXTREMITIES	☐	☐	34 NEURO	☐	☐	42 LANGUAGE
												☐	☐	43 BEHAVIORAL
												☐	☐	45 FINE MOTOR

DESCRIBE ABNORMALITIES:

Hearing

	DATE	RESULTS
AUDIO/SWEEP		P F
THRESHOLD		P F

Vision DATE / /

	FAR	NEAR
Right	/	/
Left	/	/
Both	/	/

FUSION P F

COLOR P F

Note: Screening for Amblyopi requires separate distance ac measurements in each eye an fusion test.

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

MANTOUX	DATE	RESULTS	
(PPD) IMPLANTED		1 ☐ NEGATIVE ______ MM	
READ		2 ☐ POSITIVE ______ MM	

	Chest X-ray	BCG	On INH
DATE	/ /	/ /	/ /
RESULTS	1 ☐ Normal 2 ☐ Abnormal 3 ☐ Not Indicated	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

LEAD: *Risk Assessment* DATE DONE / / RESULTS 1 ☐ No Risk 2 ☐ At Risk — If at risk, do venous lead screening DATE DONE / / RESULTS .

IMMUNIZATION — DATES Citywide Immunization Registry no.

DPT/DTaP or DT or Td 01 / / / / / / / / / / / /

IPV/OPV 11 / / / / / / / / / /

Hepatitis B 14 / / / / / / MMR 04 / / / /

HIB 13 / / / / / / VZV 21 / / / /

Other 09 / / / /

May provide copy of CIR print out in li of completing this section. Must comp CIR Number above.

DIAGNOSES — If Asthma, indicate severity

☐ Well Child V202 — ICD CODE

1.

2.

3.

DATE OF EXAM: MONTH DAY YEAR

Physician Signature

Physician Name *(Print)*

Address

Telephone

Name of facility

Type of facility: 2 ☐ HHC Child Health Clinic 9 ☐ HHC Communicare Clinic 5 ☐ HHC Hosp. Clinic 3 ☐ Private Practice 7 ☐ Comm. Health Center 4 ☐ Vol. Hosp. Clinic C ☐ School-Based Clinic 8 ☐ OTHER A ☐ SHP in School

DOH ONLY PROVIDER I.D.

TYPE OF EXAMINATION: NAE Current / NAE Prior Year(s)

Comments

Date Reviewed — I.D. NUMBER

REVIEWER

RECOMMENDATIONS/REFERRALS

1 ☐ FULL PHYSICAL ACTIVITY 2 ☐ RESTRICTIONS

Specify limitations and/or special alerts (i.e. allergies, medications, precautions)

211S (REV. 1/05)