

# 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 1 <input type="checkbox"/> Male 2 <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
1 <input type="checkbox"/> PARENT 2 <input type="checkbox"/> GUARDIAN 3 <input type="checkbox"/> FOSTER PARENT	LAST NAME	FIRST NAME	STUDENT ADDRESS	APT/FL ZIP	TELEPHONE NO. HOME: ( ) WORK: ( )
SCHOOL	DISTRICT NUMBER	1 <input type="checkbox"/> Public Elem 3 <input type="checkbox"/> Public H.S. 2 <input type="checkbox"/> Public JHS/IS 4 <input type="checkbox"/> Non-Public	SCHOOL NAME:	07 <input type="checkbox"/> Annex 1 08 <input type="checkbox"/> Annex 2	Does this child have any form of health insurance, including Medicaid or Child Health Plus?

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

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

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

**PHYSICAL EXAMINATION:** HEIGHT \_\_\_\_\_ in ( %ile) WEIGHT \_\_\_\_\_ lb ( %ile) BMI \_\_\_\_\_ ( %ile) BLOOD PRESSURE \_\_\_\_\_ / \_\_\_\_\_

GENERAL APPEARANCE (NUTRITIONAL STATUS): \_\_\_\_\_

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

DESCRIBE ABNORMALITIES: \_\_\_\_\_

<b>Hearing</b>	DATE	RESULTS	<b>Vision</b>	FAR	NEAR	FUSION	P	F	Note: Screening for Amblyopia requires separate distance ac measurements in each eye an fusion test.
AUDIO/SWEEP		P F	Right						
THRESHOLD		P F	Left						
			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		1 <input type="checkbox"/> NEGATIVE _____ MM	DATE	/ /	/ /
READ		2 <input type="checkbox"/> POSITIVE _____ MM	RESULTS	1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 3 <input type="checkbox"/> Not Indicated	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO

**LEAD:**

Risk Assessment	DATE DONE	RESULTS	If at risk, do venous lead screening	DATE DONE	RESULTS
	/ /	1 <input type="checkbox"/> No Risk 2 <input type="checkbox"/> At Risk		/ /	<input type="checkbox"/> <input type="checkbox"/>

**IMMUNIZATION — DATES**

DPT/DTaP or DT or Td 01	/ /	/ /	/ /	/ /	/ /	Other 09	/ /
IPV/OPV 11	/ /	/ /	/ /	/ /	/ /		
Hepatitis B 14	/ /	/ /	/ /	MMR 04	/ /		
HIB 13	/ /	/ /	/ /	VZV 21	/ /		

Citywide Immunization Registry no. \_\_\_\_\_

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:	MONTH DAY YEAR	DOH ON PROVIDER ID:	
1. _____		Physician Signature		TYPE OF EXAMINATION	
2. _____		Physician Name (Print)		DATE OF EXAM: (BEFORE PROCEEDING)	
3. _____		Address		DATE OF EXAM: (AFTER PROCEEDING)	
<b>RECOMMENDATIONS/REFERRALS</b>		Telephone		AB NUMBER	
1 <input type="checkbox"/> FULL PHYSICAL ACTIVITY 2 <input type="checkbox"/> RESTRICTIONS		Name of facility		TYPE OF FACILITY	
Specify limitations and/or special alerts (i.e. allergies, medications, precautions)		Type of facility		2 <input type="checkbox"/> HHC Child Health Clinic 3 <input type="checkbox"/> Private Practice C <input type="checkbox"/> School-Based Clinic	
		9 <input type="checkbox"/> HHC Communicare Clinic 7 <input type="checkbox"/> Comm. Health Center 8 <input type="checkbox"/> OTHER		A <input type="checkbox"/> SHP in School	
		5 <input type="checkbox"/> HHC Hosp. Clinic 4 <input type="checkbox"/> Vol. Hosp. Clinic			