NEW ADMISSION EXAMINATION FORM

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

Return in 2 Weeks. Please Print Clearly / Press Hard

HEALTH MESSAGE — *See Reverse Side*

STUDENT ID # / OSIS

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME | FIRST NAME | MIDDLE

SEX: ❏ Male ❏ Female

BIRTHDAY: MONTH DAY YEAR

RACE/ETHNICITY *Check all that apply*: ❏ Hispanic ❏ Asian ❏ Black ❏ American Indian ❏ White ❏ Other

❏ PARENT ❏ GUARDIAN ❏ FOSTER PARENT — LAST NAME | FIRST NAME

STUDENT ADDRESS — APT/FL ______ ZIP

TELEPHONE NO. HOME: ( ) WORK: ( )

SCHOOL — DISTRICT | NUMBER — ❏ Public Elem ❏ Public H.S. ❏ Public JHS/IS ❏ Non-Public

SCHOOL NAME: ❏ Annex 1 ❏ Annex 2

Does this child have any form of health insurance, including Medicaid or Child Health Plus? ❏ **Yes** ❏ **No**

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

If yes to any item, provide: DATE | DETAILS

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

PRES. PAST NO

- ❏ ❏ ❏ **ASTHMA** *(If present, attach medication administration form)*
- ❏ ❏ ❏ Allergies ______
- ❏ ❏ ❏ Congenital Heart Disease
- ❏ ❏ ❏ Seizures
- ❏ ❏ ❏ **Diabetes** *(If present attach medication administration form)*
- ❏ ❏ ❏ Cancer
- ❏ ❏ ❏ Orthopedic Problems
- ❏ ❏ ❏ Vision Problems
- ❏ ❏ ❏ Hearing Problems
- ❏ ❏ ❏ Speech Problems
- ❏ ❏ ❏ Hospitalizations
- ❏ ❏ ❏ Surgery
- ❏ ❏ ❏ Serious Illness
- ❏ ❏ ❏ Serious Accidents
- ❏ ❏ ❏ Other Problems/Limitations

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

GENERAL APPEARANCE (NUTRITIONAL STATUS): ______

NL AB

- ❏ ❏ HEENT
- ❏ ❏ DENTAL STATUS
- ❏ ❏ NECK
- ❏ ❏ LYMPH NODES
- ❏ ❏ LUNGS
- ❏ ❏ CARDIOVASCULAR
- ❏ ❏ ABDOMEN
- ❏ ❏ GENITO URINARY
- ❏ ❏ EXTREMITIES
- ❏ ❏ BACK
- ❏ ❏ SKIN
- ❏ ❏ NEURO
- ❏ ❏ GROSS MOTOR
- ❏ ❏ PSYCHO/SOCIAL DEV.
- ❏ ❏ LANGUAGE
- ❏ ❏ BEHAVIORAL
- ❏ ❏ 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 Amblyopia requires separate distance acuity measurements in each eye and a 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 ______ ❏ NEGATIVE ______ MM

READ ______ ❏ POSITIVE ______ MM

BLOOD-BASED TB TEST RESULTS

Name ______ ❏ POS

Date ______ ❏ NEG

	Chest X-ray	BCG	On INH
DATE	/ /	/ /	/ /
RESULTS	❏ Normal ❏ Abnormal ❏ Not Indicated	❏ YES ❏ NO	❏ YES ❏ NO

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 / / | / / | / / | / / | / / | / /

IPV/OPV / / | / / | / / | / / | / /

Hepatitis B / / | / / | / /

HIB / / | / / | / /

MMR / / | / /

VZV / / | / /

Other / / | / /

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

DIAGNOSES — If Asthma, indicate severity

❏ **Well Child V202** — **ICD CODE**

1. ______
2. ______
3. ______

RECOMMENDATIONS/REFERRALS

❏ **FULL PHYSICAL ACTIVITY** ❏ **RESTRICTIONS**

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

DATE OF EXAM: MONTH DAY YEAR

Physician Signature

Physician Name *(Print)*

Address

Telephone

Name of facility

Type of facility: ❏ HHC Child Health Clinic ❏ HHC Communicare Clinic ❏ HHC Hosp. Clinic ❏ Private Practice ❏ Comm. Health Center ❏ Vol. Hosp. Clinic ❏ School-Based Clinic ❏ OTHER ❏ SHP in School

DOH ONLY — **PROVIDER I.D.**

TYPE OF EXAMINATION: ❏ **NAE Current** ❏ **NAE Prior Year/s**

Comments

Date Reviewed: / / — I.D. NUMBER

REVIEWER:

211S (REV. 2/07)

Copies: White *(Medical Room)*, Canary *(Region)*