NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE

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: ☐ 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:

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

PRES.	PAST	NO	Condition
☐	☐	☐	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

DATE | DETAILS

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

	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: