NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE

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: 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 ❑ Yes 2 ❑ 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		DATE	DETAILS
❑	❑	❑	36 **ASTHMA** *(If present, attach medication administration form)*		
❑	❑	❑	12 Allergies _____		
❑	❑	❑	13 Congenital Heart Disease		
❑	❑	❑	14 Seizures		
❑	❑	❑	15 **Diabetes** *(If present attach medication administration form)*		
❑	❑	❑	21 Cancer		
❑	❑	❑	23 Orthopedic Problems		
❑	❑	❑	24 Vision Problems		
❑	❑	❑	25 Hearing Problems		
❑	❑	❑	26 Speech Problems		
❑	❑	❑	31 Hospitalizations		
❑	❑	❑	32 Surgery		
❑	❑	❑	33 Serious Illness		
❑	❑	❑	34 Serious Accidents		
❑	❑	❑	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 P F

AUDIO/SWEEP _____ P F

THRESHO') _____ 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 _____ 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	____/____/____	____/____/____	____/____/____			
HIB 13	____/____/____	____/____/____	____/____/____			
MMR 04	____/____/____	____/____/____				
VZV 21	____/____/____	____/____/____				

Other 09 ____/____/____ ____/____/____

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

1 ❑ **FULL PHYSICAL ACTIVITY** 2 ❑ **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 2 ❑ HHC Child Health Clinic 3 ❑ Private Practice C ❑ School-Based Clinic 9 ❑ HHC Communicare Clinic 7 ❑ Comm. Health Center 8 ❑ OTHER 5 ❑ HHC Hosp. Clinic 4 ❑ Vol. Hosp. Clinic A ❑ SHP in School

DOH ONLY — **PROVIDER I.D.** _____

TYPE OF EXAMINATION: 80 ❑ **NAE Current** 86 ❑ **NAE Prior Year/s**

Comments

Date Reviewed: ____/____/____ — I.D. NUMBER _____

REVIEWER:

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