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: ❑ 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		DATE	DETAILS
❑	❑	❑	**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		NL	AB		NL	AB		NL	AB		NL	AB	
❑	❑	HEENT	❑	❑	LYMPH NODES	❑	❑	ABDOMEN	❑	❑	BACK	❑	❑	GROSS MOTOR
❑	❑	DENTAL STATUS	❑	❑	LUNGS	❑	❑	GENITO URINARY	❑	❑	SKIN	❑	❑	PSYCHO/SOCIAL DEV.
❑	❑	NECK	❑	❑	CARDIOVASCULAR	❑	❑	EXTREMITIES	❑	❑	NEURO	❑	❑	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

DOH ONLY **PROVIDER I.D.**

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

Comments

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

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

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