NEW ADMISSION EXAMINATION FORM
DEPT. OF HEALTH & MENTAL HYGIENE — DEPT. OF EDUCATION
Return in 2 Weeks. Please Print Clearly / Press Hard

TO BE COMPLETED BY THE PARENT OR GUARDIAN

<table>
<thead>
<tr>
<th>STUDENT LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE</th>
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<th>PARENT</th>
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<tr>
<td>GUARDIAN</td>
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<td>FOSTER PARENT</td>
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<tr>
<th>DISTRICT NUMBER</th>
<th>PUBLIC SCHOOL</th>
<th>PUBLIC H.S.</th>
<th>PUBLIC HS/JS</th>
<th>Non-Public</th>
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<tr>
<th>SCHOOL NAME:</th>
<th>Annex 1</th>
<th>Annex 2</th>
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<th>District Number</th>
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TO BE COMPLETED BY THE HEALTH CARE PROVIDER

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

- Asthma
- Diabetes
- allergies
- Congenital Heart Disease
- Seizures
- PPD

PHYSICAL EXAMINATION:

- HEIGHT __________ in ( __%ile)
- WEIGHT __________ lb ( __%ile)
- BMI ( __%ile)
- BLOOD PRESSURE /_

GENERAL APPEARANCE (NUTRITIONAL STATUS):

- NL
- AB
- HEENT
- LYMHP NODES
- DENTAL STATUS
- LUNGS
- NECK
- CARDIOVASCULAR

DESCRIBE ABNORMALITIES:

- Ear
- Face
- Neck
- Eyes
- Mouth
- Teeth
- Skin

LEAD:

- Date: __________
- Results: __________
- Risk: __________

IMMUNIZATION — DATES

- Citywide Immunization Registry no.

- DPT/TdP or DT or Td
- IPV/OPV
- Hepatitis B
- MMR
- VZV

DIAGNOSES — If Asthma, indicate severity

- Well Child
- ICD CODE

- V202

- Date of Exam: __________
- Month
- Day
- Year

RECOMMENDATIONS/REFERRALS

- Full Physical Activity
- Restrictions

- Name of facility
- Name
- Address
- Telephone

TYPE OF EXAMINATION:

- NAE Current
- NAE Prior Year's

- Comments

- Date Reviewed: __________
- I.D. NUMBER

- Reviewer: __________

See Reverse Side