

***EAST RAMAPO CENTRAL SCHOOL DISTRICT***

OFFICE OF SPECIAL STUDENT SERVICES  
105 South Madison Avenue, Spring Valley, NY 10977  
Phone: (845) 577-6040  
Fax: (845) 577-6059

Dear Parent/Guardian:

The New York State Department of Education requires that all new students and students in grades kindergarten, 1st, 3rd, 5<sup>th</sup>, 7<sup>th</sup>, 9th and 11<sup>th</sup> have a physical examination completed by a health care provider. A physical examination form is enclosed in this packet. If you prefer to have your child examined by a private physician it is imperative that the completed physical examination form be returned to the school nurse by October 1.

If the school nurse does not receive the completed physical examination form, an appointment will be scheduled for your child with a school district physician. The school health physical includes an assessment of the ears, mouth, heart, lungs, spine, and genitalia. Students will also be assessed according to the Tanner stages of puberty.

Please call the school nurse indicated below with any questions or concerns.  
Thank you for your attention to this matter.

Sincerely,

Christine Healy, RN, MSN  
Coordinator of Health Services

# CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please  
Print Clearly

NYC ID (OSIS)

## TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
City/Borough	State	Zip Code	School/Center/Camp Name			District Number _____	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email			
		<input type="checkbox"/> Parent/Guardian		<input type="checkbox"/> Foster Parent				

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
<b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed  <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability <b>Explain all checked items above.</b>			<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <b>Addendum attached.</b>		
<b>Attach MAF if in-school medications needed</b>		<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile)		<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL <table border="0"> <tr> <td><input type="checkbox"/> Psychosocial Development</td> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> Lymph nodes</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Language</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> </tr> <tr> <td><input type="checkbox"/> Behavioral</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/> Back/spine</td> </tr> </table>					<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
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<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine																	
Blood Pressure (age ≥3 yrs) _____ / _____		<b>Describe abnormalities:</b>																			

<b>DEVELOPMENTAL (age 0-6 yrs)</b> Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		<b>Nutrition</b> <input type="checkbox"/> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		<b>Hearing</b> Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern: _____		<b>SCREENING TESTS</b> Date Done ____/____/____ Results <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) _____ µg/dL _____ µg/dL		<b>Vision</b> Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		<b>Dental</b> Screened with Glasses? _____ Strabismus? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Visible Tooth Decay</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Urgent need for dental referral (pain, swelling, infection)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Dental Visit within the past 12 months</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
<b>IMMUNIZATIONS - DATES</b>					
DTP/DTaP/DT	_____	Tdap	_____	IgG Titers	Date
Td	_____	MMR	_____	Hepatitis B	_____
Polio	_____	Varicella	_____	Measles	_____
Hep B	_____	Mening ACWY	_____	Mumps	_____
Hib	_____	Hep A	_____	Rubella	_____
PCV	_____	Rotavirus	_____	Varicella	_____
Influenza	_____	Mening B	_____	Polio 1	_____
HPV	_____	Other	_____	Polio 2	_____
				Polio 3	_____

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature	Date Form Completed	<b>DOHMH ONLY</b> PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	<b>TYPE OF EXAM:</b> <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ <b>I.D. NUMBER</b> _____ REVIEWER: _____
Address	City	State
Telephone	Fax	Email
FORM ID#		_____