THIS FORM MUST BE FILLED OUT BY A PARENT AND EMAILED BACK

CAMPER NAME____

DATE OF BIRTH_____/_____/_____

PARENT NAME____

HOME ADDRESS____

CITY-STATE-ZIP____

FATHER CELL_______-_______-_________ MOTHER CELL_______-_______-_________

IN CASE OF EMERGENCY CONTACT:

NAME____________________________________ NUMBER_______-_______-_______

IF YOUR CHILD HAS A CHRONIC MEDICAL CONDITION, IT IS IMPERATIVE THAT THE CAMP BE NOTIFIED.
PLEASE EMAIL THE CAMP FOR THE NURSE'S NUMBER. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

PLEASE MAKE A CLEAR COPY OF YOUR CHILD'S MEDICAL INSURANCE CARD AND PASTE THE FRONT IN THE LEFT BOX AND THE BACK IN THE RIGHT BOX. IF YOU HAVE SEPERATE PRESCRIPTION DRUG COVERAGE, PLEASE ATTACH IT IN ANOTHER SHEET. IF NO CARDS ARE ATTACHTED OR IF THE NUMBERS ARE NOT LEGIBLE YOU WILL BE BILLED FOR THE CAMPER'S MEDICAL FEES AND AND AT REGULAR DRUG STORE RATES FOR ALL DRUGS.

PASTE A CLEAR COPY OF THE FRONT OF YOUR MEDICAL INSURANCE CARD HERE.	PASTE A CLEAR COPY OF THE BACK OF YOUR MEDICAL INSURANCE CARD HERE.

MENINGITIS VACCINATION- CHECK ONE BOX BELOW

☐ MY CHILD HAS HAD THE MENINGOCOCCAL IMMUNIZATION (MENOMUNE-TM) WITHIN THE PAST 10 YEARS. DATE RECEIVED:______________

☐ I HAVE READ, OR HAVE HAD EXPLAINED TO ME, THE INFORMATION REGARDING THE MENINGOCOCCAL MENINGITITIS DISEASE. I UNDERSTAND THE RISK OF NOT RECEIVING THE VACCINE. I HAVE DECIDED THAT MY CHILD, WILL NOT RECEIVE IMMUNIZATION FOR THE MENINGITITIS DISEASE.

FOR CAMP AISH EMAIL TO: NURSE@CAMPAISH.COM

FOR CAMP AISH MESIVTA EMAIL TO: MEDICALFORMS.AISHMESIVTA@GMAIL.COM

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name

Sex ☐ Female ☐ Male

Date of Birth *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address

Hispanic/Latino? ☐ Yes ☐ No

Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ____________

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __

Phone Numbers
Home ____________
Cell ____________
Work ____________

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ________ weeks gestation

☐ Complicated by ____________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ____________

☐ Foods *(list)* ____________

☐ Other *(list)* ____________

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ____________

Explain all checked items above or on addendum

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

Dietary Restrictions
☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height ____________ **cm** (___ ___ %ile)

Weight ____________ **kg** (___ ___ %ile)

BMI ____________ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* ____________ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* ________ / ________

General Appearance:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* ____________

☐ Communication/Language ____________

☐ Social/Emotional ____________

☐ Adaptive/Self-Help ____________

☐ Motor ____________

SCREENING TESTS

	Date Done	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__ __/__ __/__ __ __ __/__ __/__ __	________ µg/dL ________ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__ __/__ __/__ __	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__ __/__ __/__ __	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__ __/__ __/__ __	________ g/dL ________ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__ __/__ __/__ __	Induration ______mm
PPD/Mantoux *read*	__ __/__ __/__ __	☐ Neg ☐ Pos
Interferon Test	__ __/__ __/__ __	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__ __/__ __/__ __	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__ __/__ __/__ __ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Hep B	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
Rotavirus		__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
DTP/DTaP/DT		__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
		__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
Hib	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
PCV	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	
Polio	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	

Influenza	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
MMR	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Varicella	__ __/__ __/__ __	__ __/__ __/__ __	
Td	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Tdap __ __/__ __/__ __ Hep A		__ __/__ __/__ __	__ __/__ __/__ __
Meningococcal	__ __/__ __/__ __	__ __/__ __/__ __	
HPV	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Other, *Specify:* ________	__ __/__ __/__ __ ;	________	__ __/__ __/__ __

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* ____________

Follow-up Needed ☐ No ☐ Yes, for ____________ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other ____________

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

____________ __ __ __ __ __

____________ __ __ __ __ __

____________ __ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __ __/__ __/__ __ I.D. NUMBER ☐☐☐☐☐☐

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian